NAMD
National Association of Medicaid Directors

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Dear Mr. Cavanaugh, Dr. Conway and Ms. Bella,

We appreciate the time you spent with us discussing the collaboration between states and CMS to improve integration for the Medicare-Medicaid dually eligible population, including the dual eligible demonstration programs and the Medicare Advantage Dual Eligible Special Needs Plan (D-SNPs). We write today to follow-up on several items we raised with you.

As you know, states remain interested in the existing and new opportunities that may emerge to improve care coordination for the dually eligible population.

Integration and alignment between the two programs continues to be a top priority for states. In fact, in our 2014 State Medicaid Operations Survey, nearly two-thirds of Directors indicated their states were planning, implementing, or actively working to improve their LTSS programs, with over a quarter of Directors naming LTSS as one of their top three priorities for the coming year. Initiatives for the dually eligible population were primarily focused on efforts to leverage managed long-term services and supports for the delivery of care to this population.

Medicaid Directors are clearly prepared to explore new avenues with you. We hope to continue to work with you to advance the following the proposals and requests.

Articulate next steps for existing financial alignment demonstrations. States and CMS have forged a historic partnership to design and launch the financial alignment and other duals demonstrations. On the ground, health plans, providers and consumer organizations are an essential component to these efforts. Through these partnerships, we have already learned many lessons about alignment of the programs and coordination for enrollees. We expect forthcoming evaluations will reveal early successes, areas for improvement and other opportunities.

However, we believe federal policymakers must begin to engage with states to plan for the next steps for demonstrations. States are eager to understand CMS' long-range work plan for the demonstrations, including whether these will continue during the CMS evaluation period.

States need certainty around CMS' continued support and authority for these complex programs for the following two reasons:

1. States want to prevent or minimize disruptions for enrollees that may be required by future transitions. Continuity of care planning is critical and requires significant advance notice and planning.

2. States also need this guidance to inform their own internal planning and budget processes.

Enhance existing integration pathways and develop new approaches. CMS, states, plans, providers and many other stakeholders will continue to learn from the existing demonstrations and D-SNP experiences. However, we believe there are important lessons CMS can incorporate in the immediate term and sufficient interest from additional states that wish to pursue integration opportunities to improve care coordination. We encourage CMS to continue to work with NAMD and our members on the following issues:

1. A growing number of states are interested in leveraging the D-SNP pathway. About 1.7 million dually eligible beneficiaries are already served in D-SNPs under contracts or agreements with states that are required by statute. These current contracts *do not* require demonstration authority and thus are well suited to become a preferred pathway to achieve meaningful improvements for beneficiaries.

   We recognize that Medicare cannot accommodate each individual state's specific issues and program nuances. However, we request that CMS identify a menu of administrative flexibilities or options for which states could choose to partner with Medicare to improve access to integrated services and care coordination *outside of* demonstration authority. States and health plans will need additional resources and clear guidance on these tools, including through enhancement of their Medicare Improvements for Patients and Providers Act (MIPPA) contracts. In particular, many states have or are building Medicaid managed long-term services and supports (MLTSS) programs that they could leverage to drive alignment with D-SNPs via the MIPPA vehicle. We appreciate that CMS' Integrated Care Resource Center has already undertaken important work to assist states in this area, and we believe additional and ongoing resources are needed to work with states that choose this pathway.

2. Several states also remain interested in evolving or newly a managed fee for service or similar demonstration model. We request that CMS continue to work with these states to find a path to a more flexible shared savings model that would allow states to capture first dollar savings as opposed to having to exceed statistical significance before any savings are shared.

3. Finally, as you consider new proposals or pathways to improve care coordination and alignment with states, a strong testing environment with states with ample time for assessing system readiness is critical. While we acknowledge that there were state-specific system challenges that arose with the current demonstrations, we believe many of these could have been mitigated had there been more comprehensive end-to-end testing of all systems. Without end-to-end testing, the opt-in period becomes the 'testing environment' resulting in avoidable enrollment challenges for both states and beneficiaries. In addition, a crosswalk of existing CMS Medicare or Medicare Advantage guides for certain processes, such as enrollment, would help to minimize enrollment disruptions and the need for state system rework.

Immediate changes to improve access to integrated and coordinated services for dual eligible. All Medicare-Medicaid dually eligible beneficiaries should have timely access to integrated and coordinated services. This is true regardless of whether an individual is enrolled in a demonstration program, a D-SNP or some other integration pathway. We believe the following steps would bring CMS and states closer to realizing this goal.

1. *Strengthen the state options to promote enrollment continuity.* State Medicaid agencies currently have authority – and extensive experience with – administering passive enrollment, mandatory enrollment and lock-in policies for the Medicaid portion of the beneficiary's services. We continue to believe that parallel authority is needed for the Medicare component of the benefit package. Today beneficiaries may enroll in different health plans for their Medicare and Medicaid benefits or they may be required to enroll in a Medicaid health plan but remain in the unmanaged Medicare

fee-for-service program. These situations make it difficult for states to facilitate better-coordinated and beneficiary-centered care that could be available by combining the full continuum of services dual eligibles need into a single benefit package, delivered by a single organization responsible for coordinating all services.

In addition, there are still many instances where individuals are unintentionally disenrolled from their Medicare or Medicaid plan or demonstration program for a short period of time. We respectfully request that CMS provide more flexibility for states to address situations where there is a short break in enrollment so states can reconnect individuals automatically to the same plan they had been in. We believe this is most respectful of member preferences and appropriately prioritizes the integrated care that we believe can improve member outcomes. Putting states or the plans at risk for this is not a viable option in this demonstration environment.

2. *Streamline beneficiary notices and communications.* We recognize that Medicare is a single national program, and as such it unreasonable to allow each state to deviate from the program's uniform approach to notices and communications with Medicare eligible individuals. However, we also believe Medicare and Medicaid share the goal of simplifying materials and processes for all dual eligible enrollees, as evidenced by some of the adaptations that have been made through the current duals demonstrations. Streamlined notices would ensure enrollees have clear, consistent information regardless of whether they are enrolled in a demonstration program, D-SNP or other integrated programs that may develop.

   Therefore, we urge you to advance opportunities to streamline the notices and communications within the current demonstration environment as well as with D-SNPs and future integration initiatives. The states' goal is to minimize confusion for enrollees. We believe that state Medicaid agencies can leverage their extensive experience and ongoing collaborations with

plans, providers and consumer advocacy organizations to tailor letters to this vulnerable population to accomplish this goal.

3. *Advance requests for "seamless conversion."* Working with CMS, states remain interested in improving care coordination for enrollees using the regulatory and statutory authority for plans to conduct seamless conversion. As you know, CMS' current policy faces technical barriers with identification of individuals who will become eligible for Medicare based on reaching the end of their 24-month Medicare disability waiting period, including the lag in receiving necessary information from the Social Security Administration. It is our understanding that the current construct has thus far prevented any state from being permitted to fully implement "seamless conversation," therefore invalidating the existence of an option for states.

   We request that CMS allow states and plans to move forward with seamless conversion for both or either the aging and persons with disabilities, even when there are technical barriers in the process to identify all individuals who are aging into Medicare. Enrollees would still have the option to decline to participate in a D-SNP, thereby preserving the important beneficiary protections already in place to allow for disenrollment without penalties to the health plan or member. In other words, beneficiaries would not "lose" choice and autonomy by participating in seamless conversion—most beneficiaries have enrollment choices for their Medicaid benefits, and, if they are happy with their current plan, states are trying to facilitate a truly unbroken experience on the Medicare side.

   "Seamless conversion" enhances the opportunity for states and health plans to meaningfully participate in care coordination activities. We believe this approach is consistent with our shared goals around protecting enrollee choice and improving care coordination.

4. *Formalize process for plan audit activities.* We appreciate that CMS is piloting an effort to notify states when Medicare initiates plan audits for D-SNPs and as part of the collaborative oversight process with MMPs. We also request that CMS formalize a process to share plan audit findings with the state Medicaid agency.

   We believe CMS should standardize these types of communications with *all* states that have signed MOUs with D-SNPs or that are participating in the financial alignment demonstrations. Doing so will allow us to establish new partnerships and strengthen those that already exist in our work on quality improvement.

Address Components of the CMS-HCC which have a disproportionate, adverse impact on SNPs. We also find compelling analysis of the disproportionate impact on SNPs from the CMS-Hierarchical Condition Categories (HCC) risk model. Specifically, the HCC model does not take into account functional impairment – a significant issue for dual beneficiaries -- and research indicates that the CMS-HCC underpays for comorbidities. In particular, we note this is supported by a study titled, "An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures," which was prepared for the National Health Policy Group by Milliman. Milliman's analysis indicates there are shortcomings of the CMS-HCC risk model, which result in a disproportionate impact on SNPs.

While we appreciate that CMS' methodology was designed to deter inappropriate coding, we believe this has over time led to insufficient reimbursements paid to SNPs who treat frail patients with multiple chronic conditions. We encourage CMS to analyze modifications to the HCC that could help ensure payment equity for plans that exclusively or disproportionally serve dually eligible beneficiaries with FFS providers and to enhance their capacity to address beneficiaries' special needs.

Address Inconsistencies in Star Rating System. We were pleased to see CMS' Request for Information to health plans, drug plans, clinicians, advocacy

organizations, consumers, and associations such as ours regarding whether Medicare-Medicaid dual status causes lower MA and Part D measure scores.

While NAMD has not undertaken the type of detailed analysis you seek, we believe the evidence is compelling to indicate dual status *does* cause lower scores. We urge CMS to modify the application of the star rating system to D-SNPs to ensure it does not inappropriately penalize some D-SNP plans.

We are aware of existing research which shows that the star rating system has been a systematic challenge for plans serving these Medicare members due to the population's complex medical needs, socioeconomic factors and other factors impacting the delivery of care. By definition, these populations typically have far more complex medical issues and represent the most underserved populations. Among the recent studies and research which show the relationship between socioeconomic and demographic factors and health plans' performance are the National Quality Forum's August 2014, report titled, "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," and Inovalon's October 2014, report titled, "An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures — Part 1: Member Level Analysis."

The current rating system does not include population-specific measures for all SNP enrollees related to complex chronic care management. For example, it lacks appropriate focus care coordination measures focusing on how well providers and organizations coordinate services and care transition measures that are more meaningful.

Based on publicly available research and states' on-the-ground experience working with D-SNPs, we believe the existing structure of the star rating system disadvantages these plans We also believe CMS should undertake more rigorous evaluation of existing research or expeditiously conduct its own analysis to determine whether high quality performance in Medicare Advantage or Part D plans can be achieved in plans serving dual eligible beneficiaries.

We appreciate the difficult of trying to align Medicare's national approach with the diverse state Medicaid programs. However, without a clear alternative to reform the overall approach to low-income aging individuals and people with disabilities, we believe we must continue forge ahead with innovations that will improve the quality and coordination of services for this most vulnerable population.

Sincerely,

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