JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

March 1, 2019

Centers for Medicare and Medicaid Services
Attn: CMS-2018-0154
P.O. Box 8016
Baltimore MD 21244-8010

Submitted electronically: regulations.gov

Re: CMS-2018-0154: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Notice.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Our comments primarily address four areas where the Call Letter specifically asks for information and comment: special supplemental benefits for the chronically ill; D-SNP administrative alignment opportunities; D-SNP look-alikes; and Medicare Advantage organizations crossing claims over to Medicaid agencies. Our responses are grounded in our long engagement with issues around dual eligibles and the information we receive from on-the-ground advocates working with these populations. They also reflect our deep engagement with the financial alignment demonstrations for dual eligibles and the learnings from that program.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

We fully endorse the thoughtful comments of the National Council on Aging and incorporate them here by reference. In addition, we wish to emphasize the following points.

Contracting with community-based organizations: We appreciate that CMS has clarified and emphasized that plans can contract with CBOs. Many CBOs have decades of experience and are trusted service providers. We note, however, that their business practices can differ substantially from those of corporate health plans and that meshing systems can be challenging. This happened in the dual eligible demonstrations and caused disruptions. CMS has offered technical advice and training both to CBOs and to plans in the demonstrations on some of these issues. We urge CMS to address these issues more broadly with MA plans outside the demonstrations and, importantly, that CMS insist that plans

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

thoroughly test compatibility of business practices with their CBO partners before commencing services.[1]

Improving health or function: As CMS has noted, the Bipartisan Budget Act requires that an SSBCI must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease. The consistent position of CMS with respect to maintenance of health in the context of other regulations has been that "maintaining" incorporates slowing decline or loss of function, a recognition incorporated in the settlement agreement of the landmark "improvement standard" case, *Jimmo v. Sebelius* and in regulations and guidance.[2] We are concerned, however, that at page 163 of the draft Call Letter, CMS states that a benefit may not be provided "if that benefit does not have a reasonable likelihood of improving that specific enrollee's health or overall function as related to the specific chronic illness." Limiting benefits to those that "improve" is inconsistent with the statute and with CMS policies. It also fails to recognize that many chronic conditions are not amenable to improvement. Instead, managing decline and minimizing loss of function can significantly affect quality of life, prevent costly hospital visits, and avoid or delay institutional placement. We ask CMS to clarify and emphasize to plans that expectation of improvement is not a requirement for SSBCI and that maintenance includes preventing or slowing a decline in condition.

Considering other factors*:* CMS asks whether it should permit consideration of other factors, like financial need, in determining permissible supplemental benefits. We do not believe that supplemental benefits should be means-tested. It is important, however, that a plan's menu of supplemental benefits should be helpful, accessible to and appropriate for beneficiaries with low incomes. It also is important for CMS to track utilization to ensure that a plan's supplemental benefits package, in practice, is not skewed toward higher income beneficiaries.

Cultural competence: We urge that CMS require that MA plans offering congregate meals, home-delivered meals and similar benefits do so in a culturally competent manner, for example serving meals appropriate to ethnic tastes or ensuring that individuals in congregate social settings are not isolated in a program where no other participants speak their language. Contracting with community-based organizations already serving distinct communities can be an effective strategy to achieve these goals.

Home improvements: We are concerned that the broad warning in the Call Letter against any home improvement that could potentially increase property values will lead MA plans to avoid almost any home modifications for fear of running afoul of CMS policy. Ramps, for example, are unlikely to have any substantial impact on property values and might, in fact, have a slight negative impact. Yet they may have a very substantial impact on the ability of an individual to live at home safely and with maximum independence. We urge CMS to consult with the real estate community to better determine what assumptions about home value are valid and develop a more nuanced policy on home improvements, perhaps with safe harbors.

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[1] We also raise this issue later in these comments in the context of D-SNP alignment.

[2] The text of the settlement agreement is available on the CMS *Jimmo* Settlement page, www.cms.gov/Center/Special-Topic/Jimmo-Center.html. See also, e.g., 42 C.F.R. 409.32(c); and MLN Matters, "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*," (Jan. 2014), available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf.

Appeals of denial of supplemental benefits: We appreciate that CMS has emphasized that denials of SSBCI are subject to appeals. We ask that CMS publish data on SSBCI appeals. We also ask for CMS monitoring to ensure that complaints about supplemental appeals are properly categorized and that beneficiaries are not discouraged from appealing denial of requested services.

Data collection: We ask that CMS closely monitor and collect data on: the types of SSBCI offered by plans; the number of beneficiaries actually receiving SSBCI in plans; the demographics of those receiving benefits; and the impact on health outcomes. We also ask that CMS make this information available publicly. Robust data collection around supplemental benefits is important for several reasons.

These benefits are new and it is important to learn how they play out. Data collected in the dual eligible demonstrations provide instructive examples. Annual charts from MMCO on the average number of supplemental benefits offered by Medicare-Medicaid plans have provided useful information for analysis.[3] Similarly data available on the performance of Medicare-Medicaid plans in the California dual eligible demonstration showing low levels of assessment and utilization for Care Plan Option (CPO) services (similar to supplemental services) helped stakeholders craft recommendations for improvements.[4]

Further, demographic information can help determine if the benefits are being offered in a non-discriminatory manner and also to pinpoint areas where communication to beneficiaries about SSBCI needs to be strengthened. In addition, data collection, particularly on health impact, can help inform discussions on broader policy issues, including the potential to incorporate some of these benefits into Original Medicare.

D-SNP "Look-alikes"

We have very serious concerns about D-SNP look-alikes. We believe that CMS should do all that it can to stop marketing of these products, which do not genuinely serve the needs of duals and also, more importantly, interfere with the development of truly integrated products that are subject to specific rules and oversight. We will discuss specific concerns as well as proposals further below.

To start, however, we note that no health insurer is required to enter the Medicare market. They choose to do so because the market can be profitable. For the privilege of participating in Medicare Advantage, it is reasonable for CMS to require a basic commitment to support and not interfere with the broader goals of the agency, including its goal to better serve the needs of dual eligibles for coordination of their Medicare and Medicaid benefits. CMS and the states are working on many models to achieve these goals including Medicare-Medicaid plans, managed fee for service, D-SNPs and PACE. Congress has supported those efforts throughout by establishing the Medicare-Medicaid Coordination Office, permanently authorizing D-SNPs, and establishing and funding demonstration authority for the Center

[3] The summary released in 2019 is available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPSupplementalBenefitsCY201901162019.pdf.

[4] See Justice in Aging, "Cal MediConnect: Unmet Need and Great Opportunity in California's Dual Eligible Demonstration" (Feb. 2019) (note especially Appendix B), available at www.justiceinaging.org/wp-content/uploads/2019/02/Cal-MediConnect-Unmet-Need-Great-Opportunity-in-CAs-Dual-Eligible-Demonstration.pdf?eType=EmailBlastContent&eId=22c18f70-e7cf-46d5-9359-5bd26d7b4276.

for Medicare and Medicaid Innovation. We think it is only reasonable and well within the scope of CMS's authority for the agency to require that any plan sponsor wishing to specifically target the dual eligible market do so by offering only products that CMS has determined appropriate for dual eligibles and that are regulated by CMS as dual eligible products.

Impacts of look-alikes

Beneficiary engagement: The dual demonstrations have included multiple opportunities for stakeholder involvement in plan design and execution, both in planning and throughout the plan implementation. Structured engagement of beneficiaries and their advocates has both empowered beneficiaries and led to significant innovation in the demonstrations. See, for example, the work of the Implementation Council and the involvement of Disability Advocates Advancing our Health Care (DAAHR) in the One Care dual eligible demonstration in Massachusetts.[5] Though the situation with D-SNPs currently is mixed, we expect that future state contracts will also require these plans to incorporate beneficiary voices, a requirement that is particularly important for the diverse individuals served by D-SNPs. No such structure is required or, to our knowledge, exists with look-alikes.

MA plan sponsor commitment: CMS, states, and beneficiary advocates entering into the dual eligible demonstrations had an expectation that participating plan sponsors were fully committed to the demonstrations. Yet it appears that some of those sponsors acted to create competing products and put as much or more effort into recruiting members for those competing plans, apparently perceiving them to be more profitable. More generally, the divided loyalties of some plan sponsors inevitably lead to questions about the extent to which plan sponsors fully support integration. Our concerns are similar with respect to plan sponsors that do not offer D-SNPs and do not participate in dual eligible demonstrations but instead decide to aggressively seek out dual eligible beneficiaries while skirting the regulatory framework designed to support the goals of integration. They too draw beneficiaries away from more integrated options, and confuse the market without offering added value.

Providers/improper billing: We are not privy to how look-alike plans negotiate with their providers but something is clearly out of kilter. If a provider looks at a look-alike plan's design on paper and decides to join the plan network, that provider would reasonably expect that, besides the contractual amount received from the plan, the provider would collect from most plan members significant co-insurance payments. In fact, looking at MedPAC numbers, over 90% of the time the provider would be prohibited from collecting any amount because of the enrollee's dual status. Further, given the "lesser of" policy with respect to Medicaid payments for QMBs and the current difficulties (discussed later in the Call Letter and in our comments below) for Medicare Advantage providers in even filing tor such payments, the provider would almost always receive nothing or next to nothing from any source other than the contracted amount from the plan. We question whether look-alike plans have shared this financial reality with providers when negotiating rates and, if not, whether the failure to do so was a material misrepresentation to providers. We also question whether plan design and cost and benefit projections

[5] See Implementation Council site at www.mass.gov/service-details/one-care-implementation-council and DAAHR site at https://bostoncil.org/advocacy/daahr/. See also discussion at Kaiser Family Foundation, "Early Insights from One Care: Massachusetts Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries" (May, 2018), available at www.kff.org/medicaid/issue-brief/early-insights-from-one-care-massachusetts-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/.

presented to CMS when seeking approval for their look-alikes genuinely reflected the easy-to-anticipate and disproportionate loss of co-insurance income by providers.

From a beneficiary point of view, a plan with high co-insurance amounts that are actually phantom substantially increases the risk of improper billing. We have seen multiple instances of such billing in California look-alikes. Similarly, though providers are contractually prohibited from discriminating against plan members protected from improper billing, we have serious concerns that look-alike network providers will find ways to avoid serving look-alike plan members so they can focus on more profitable patients.

Impact on counselors: It is our experience that look-alikes have confused SHIP counselors and other advocates who assist beneficiaries in navigating their Medicare choices. In many cases counselors had no idea that look-alikes were operating in their area. The lack of transparency about these plans made it difficult for counselors to provide informed advice. We even heard from a broker who was shocked to learn that she was marketing a look-alike and not a D-SNP to dual eligible clients she was trying to help. Those SHIP counselors who were aware of look-alikes reported multiple instances where an individual enrolled in a look-alike after a convincing sales pitch and, after finding out that the look-alike did not meet the beneficiary's needs, was desperate to change plans. Advocates have also reported many instances of improper marketing of look-alikes, particularly to beneficiaries with limited English proficiency and in rural communities.

Impact on integration: The promotion of look-alikes has had a serious impact on the development and sustainability of integrated care products for dual eligibles. In demonstration states, stakeholders, states and CMS devoted countless hours to develop duals-specific consumer protections, to set care coordination standards, to smooth the appeals process for services that might cross Medicare and Medicaid, to establish reporting requirements and oversight mechanisms and much more. Yet look-alikes swept into the market with no transparency and no state contracts. None of the protections and requirements in the demonstrations applied to look-alikes and they faced no real accountability for their service to dual eligibles. In California, though the state tried to clear the way for a vigorous demonstration by limiting D-SNPs in demonstration counties, the look-alikes largely negated that effort, enrolling almost as many beneficiaries as were enrolled in the demonstration. They effectively stunted the growth of the demonstration and, by convincing dual beneficiaries that their plans were appropriate for them, deprived duals of the opportunity to join a plan that actually met requirements for integrated care.

Impact on evaluation of demonstrations: Particularly because they were under-the-radar through much of the demonstration, the look-alikes skewed analysis of enrollment dynamics in demonstration counties. In California, for example, much of the narrative in the early years of the demonstration was around blaming lower than expected enrollment on beneficiaries who refused managed care and their providers who scared their patients away from the demonstration. In fact, it was the plans that were strategically and systematically enrolling people into alternative products and many patients of those providers ended up in look-alikes, presumably with the acquiescence of those same providers.

Addressing the problem

Justice in Aging urges CMS to work to eliminate look-alikes or curtail them as much as possible. We stress that the rise of look-alikes and their negative effects on beneficiaries and on integration efforts is the result of plan actions, not beneficiaries' and that efforts to fix the problems they create should focus on plans. We find it distressing that some solutions proposed by some D-SNPs and demonstration plans, and echoed by MedPAC,[6] put the onus on the beneficiary—initiate more passive enrollment, lock the beneficiary in, further limit opportunities to change. Beneficiaries did not create this issue, plan sponsors did. They took advantage of Medicare Advantage rules so they could offer plans targeting dual eligibles without conforming to the requirements that CMS and states have put in place to ensure that plans serve this population well.

As the Call Letter notes, CMS can use its authority under 42 C.F.R. 422.2268 to prohibit misleading communications by plans. We also urge that CMS, by regulation, use the broad authority under 42 U.S.C. 1395w-26(b), to rein in look-alikes. We also support CMS's commitment to closely monitor look-alike marketing both for misrepresentations and for possible violations of non-discrimination requirements. We further urge CMS to look closely at bid submissions from look-alike plans to understand the underlying financial assumptions in those bids and their validity in light of the fully predictable lopsided plan enrollment patterns. We offer the following additional suggestions of measures that, separately or in combination, may be effective:

D-SNP classification: Treat any plan with membership of at least 80% dual eligibles as a D-SNP subject to the regulatory requirements for D-SNPs, including the requirement for a contract with the state. Since 80% membership demonstrates that a plan is overwhelming serving duals, we believe this approach is consistent with Congressional intent in the D-SNP definition in 42 U.S.C. 1395w-28W(b)(6).

Contractual commitments: Require that any plan sponsor seeking a contract to offer an integrated product agree, as a condition of the contract, that the sponsor will not offer a non-integrated product in the same service area that enrolls more than 25% dual eligibles and/or has a plan design that appears to be particularly attractive to dual eligibles. CMS can set parameters on the design elements subject to this requirement.

Marketing materials: Require that plan agents and brokers, when engaging in one-on-one marketing for an MA plan that is not a D-SNP or demonstration plan, must determine whether the beneficiary is a dual eligible and, if so, must explain both orally and in writing that the plan is not an integrated product and does not have a contract with the state to coordinate Medicaid benefits. If there are integrated products being offered in the plan service area, the written document must list them and provide contact information. The written document should be a standard document prepared by the plan and reviewed by CMS.

Outbound Verification Call: Require that, upon receipt of the application of a dual, any non-integrated plan must initiate an outbound verification call to confirm that the dual eligible beneficiary understands the limits of the plan. The plan representatives should be trained on how any supplemental benefits offered by the plan overlap or interact with the Medicaid benefits in that state and affirmatively offer

[6] June 2018 MedPAC Report to Congress, pp. 276-281, available at http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0.

assistance to the beneficiary in understanding the basic relationship. Any dual eligible who enrolls in a non-integrated plan should at a minimum understand how the plan does and does not coordinate Medicaid benefits.

Education of SHIP counselors: CMS should provide materials and training for SHIP counselors on the availability of integrated products in their area and the identity of non-integrated products with high dual eligible enrollment.

Provider notice: Require that when a non-integrated plan has, expects to have, or based on its design is reasonably likely to have an enrollment of more than 25% dual eligibles, the plan must provide special notice to prospective and current in-network providers stating that the providers will be prohibited from collecting co-insurance from a significant percent of their patients. The notice must also explain how providers can seek payment from state Medicaid programs, explain the limits of the "lesser of" policy, and fully explain improper billing protections. Additionally notices should articulate the duty of providers not to discriminate against plan members on the basis of payment source, and the potential consequences of violating these rules.

D-SNP Administrative Alignment Opportunities

We appreciate the commitment of CMS to continue to seek opportunities to create better alignment between the Medicare and Medicaid programs. Most importantly, alignment makes the programs easier for beneficiaries to navigate. Alignment provides efficiencies for states and plans, removing obstacles to efficient delivery of care and facilitating a more coordinated response to the needs of dual beneficiaries.

Our thoughts on specific efforts that CMS has undertaken and on opportunities for further alignment initiatives are set forth below. We begin with the four current efforts highlighted in the Call Letter, then set out other areas where we would favor additional alignment initiatives.

Current Initiatives

Default and passive enrollment: We recognize the advantages of alignment in enrollment and also appreciate that CMS has narrowed the circumstances in which passive and default enrollment occur. We continue, however, to urge CMS to require acquiescence by beneficiaries before an enrollment is finalized. Passive opt-out enrollment is simply not the appropriate start to care that seeks to be person-centered. In the dual eligible demonstrations, it routinely sparked confusion and was a contributing factor to high opt-out rates.

Flexibility in design of integrated beneficiary communications: We appreciate the work that CMS is undertaking to develop simpler and more integrated documents to communicate benefit information to plan enrollees. The financial alignment demonstration has produced some very good examples of clear communication and has also demonstrated the confusion and backlash that can result when communications are too complex and have not been consumer tested. We strongly urge that development of integrated documents include consumer input throughout the process and that documents be subject to consumer testing. We also hope that as state-specific documents are developed in Massachusetts, Minnesota, and New Jersey, CMS will share them and the learning from their development with other states and provide guidance for best practices.

Sharing plan performance information and audit results: We very much appreciate this initiative. Performance and audit information will assist states in deciding whether to contract with proposed D-SNPs. Further, this information will help states understand the strengths and weaknesses of the D-SNPs with which they do contract, which should assist in contract negotiation and oversight.

Integration of state expectations into Models of Care: Our experience is that Models of Care (MOCs), though potentially important vehicles for driving innovation, have not yet lived up to their potential. A process for incorporating state expectations and aligning models of care with commitments in state contracts could certainly help to make the MOCs more robust instruments. We are not aware of how the timelines for state contracting processes and timelines for developing and getting CMS approval for Models of Care mesh but suggest that they be synchronized.

We also ask for more transparency around MOCs. Currently scores for D-SNP MOCs are publicly available[7] but the MOCs themselves are not easy to find. To our knowledge, any CMS evaluations of how D-SNPs implemented their MOCs are not available at all. The value of MOCs could be strengthened if more information were easily available and if the MOCs and the D-SNPs' progress in implementing them were routinely incorporated into the stakeholder engagement process.

We also note the challenges of creating meaningful MOCs for D-SNPs that enroll both full and partial dual eligibles. If CMS and/or states decide to permit D-SNPs that enroll partial duals, we ask that, in reviewing MOCs in those states, CMS pay particular attention to whether the MOC addresses the needs of both populations.

Proposed additional areas:

Durable Medical Equipment (DME): DME alignment faces multiple challenges. For D-SNPs operating in states with fee-for-service Medicaid or where individuals are enrolled in a non-matching Medicaid managed care plan, beneficiaries may face the need to use multiple DME suppliers unless the D-SNP network suppliers also are enrolled in the state Medicaid program. Even when a D-SNP has a matching Medicaid managed care product, there is no current requirement that DMS suppliers align. We urge CMS to consider requiring supplier alignment.

Streamlining the information requested from providers to support DME approval is another area of alignment. Whether or not the D-SNP has a matching Medicaid plan, it would be helpful if the supporting information collected from the prescriber included all that is needed for either Medicare or Medicaid review. Ideally, there would be single form acceptable to both the D-SNP for Medicare review and to the state Medicaid program and/or its managed care plans. This would lessen the burden on prescribers and avoid delays when Medicaid review is needed.

Alignment of supplemental benefits with Medicaid coverage: We have continuing concerns, already raised with CMS, about ensuring that supplemental benefits offered by D-SNPs complement but do not overlap with Medicaid-covered services. We have seen many problems where, for example, beneficiaries are enrolled in Medicare Advantage plans or Medicare-Medicaid plans that offer partial dental or vision coverage that overlaps with more extensive Medicaid coverage, although provider

[7] See NCQA, "CY 2019 Model of Care Scores", available at https://snpmoc.ncqa.org/model-of-care-scores/.

networks do not overlap. To promote alignment, we ask that when CMS reviews the supplemental benefit packages proposed by D-SNPs, the agency, with input from the state, only approve services that complement, rather than duplicate Medicaid coverage.

Further, if a D-SNP offers supplemental benefits that do, in fact, complement Medicaid coverage, beneficiaries ought to be able to use the same provider and not have to jump between a D-SNP provider and a Medicaid provider depending on what treatment needs arise. The issue comes up with dental coverage but can appear in other areas as well, such as transportation benefits. A D-SNP might offer transportation to senior centers or to a pharmacy to supplement non-emergency transportation Medicaid benefits that offer rides to medical providers. If beneficiaries do not have one number to call, they may well be charged for using the wrong service or denied transportation they believed was covered.

There might be several steps that could help with this provider alignment. The ideal alignment would be for all D-SNP providers to be enrolled in the state Medicaid program. We recognize, however, that such a requirement may interfere with the D-SNP's ability to recruit a robust provider network. We propose that CMS consider some additional potential avenues to address the issue. States could provide D-SNPs with the identities of all their contracted providers of services that might overlap so D-SNPs could consider recruiting those providers to join their networks. On the flip side, we have thought about the procedure used by some states to offer abbreviated short-form applications for providers who seek Medicaid enrollment solely for purposes of receiving crossover claim payment for QMB beneficiaries. States could consider offering abbreviated—or automatic—enrollment for D-SNP providers solely for the purpose of providing Medicaid-covered services to members of the D-SNP. For example, in a D-SNP offering supplemental dental services, the state could enroll the D-SNP dentist in Medicaid with little or no paperwork with the limitation that the dentist only provide services to D-SNP members. This would allow a D-SNP member to use one provider for an entire oral health treatment plan but would also accommodate providers unwilling to serve Medicaid patients more generally. We expect that if this approach were pursued, it would require guidance from CMS endorsing the procedure.

Language access: In the dual eligible demonstrations, the three-way contracts required that translation requirements for beneficiary communications meet either state or federal requirements, whichever were most beneficialto the enrollee. This common-sense requirement ensures that beneficiaries consistently get the same level of language access for both their Medicare and Medicaid benefits. We ask that CMS make this a requirement for all D-SNPs.

Coordinated State-Federal oversight: In the dual eligible demonstrations, we have seen real value in the use of federal-state Contract Management Teams (CMTs) that meet regularly to review ongoing progress and also are available to address issues on an ad hoc basis. We believe it is important to put similar mechanisms in place for D-SNPs to ensure consistent oversight and coordination between state and federal regulators and to work out any issues arising from inconsistencies or misunderstanding in regulatory directives.

State commitment to alignment: In states where Medicaid services are provided in a fee-for-service program or where some services are carved out from Medicaid managed care, it is critical that states make a commitment to support alignment of services and back that commitment with concrete actions. We saw, for example, in the Cal MediConnect demonstration that midway through the demonstration, the state stopped paying for representatives of In-Home Supportive Services (IHSS—a carved out

program in California) to participate in care coordination meetings. Not surprisingly, IHSS social worker participation dropped off sharply and care coordination suffered because this key service provider was not at the table. One specific impact was that plans lost a venue where they could advocate for increased IHSS hours for members.

The need for state commitment also is significant if the state allows membership in non-matching Medicare and Medicaid managed care plans.

To improve alignment, states could require, in their contracts with entities providing carved out services and their contracts with all Medicaid managed care organizations, that those entities enter into information sharing agreements with D-SNPs in the state and that Medicaid providers participate in care coordination activities. California, in its dual eligible demonstration, imposed such a requirement on providers of carved out behavioral services and it improved care coordination. States may need to include the added costs of coordination in their contracts with those entities.

Aligned business practices: In the dual eligible demonstrations, we saw significant problems in alignment of business practices between providers of Medicaid-covered services and demonstration plans. Perhaps the most striking example was in Ohio where the way that home care providers recorded their time did not mesh with how managed care plans handled payment, with the result that many providers, themselves low-income individuals, were not paid. Many home care providers reluctantly left their jobs, leaving beneficiaries stranded without anyone to meet their most basic daily needs, at least until the plans and state ultimately hammered out solutions.[8] There have also been multiple less dramatic instances of adult day health programs and other key providers facing cash flow shortfalls because of technical issues with payments from demonstration plans. These nuts and bolts issues are critically important especially because many providers of home and community-based services are nonprofits with limited resources to weather temporary financial storms. We appreciate that CMS has supported technical assistance in these areas and urge continued attention to these issues, including specific guidance to plans on their obligations to identify and work out technical issues with contracted providers before, rather than after, commencing services to beneficiaries.

Ombuds: The success of ombuds programs in the financial alignment demonstrations has shown the need for and value of beneficiary assistance that can address both Medicare and Medicaid issues. In the dual eligible demonstrations, ombuds programs have proved to be invaluable in identifying systemic problems as well as assisting in individual cases. In many instances, ombuds have been able to avoid appeals by identifying administrative or technical problems that led to a denial. We strongly urge CMS to establish dual eligible ombuds in states with D-SNPs and to support the ombuds programs both financially and with technical assistance.

Working level alignments: There is much room for alignment at the granular level. For example, though we recognize that a universal health risk assessment tool as an ideal not yet reached, we do believe that there is much that could be done in the short and medium term to ensure that D-SNP assessments use the same terminology as state Medicaid programs and that D-SNP coordinators are fully aware of state Medicaid requirements. Similarly, data collection should use categories that mesh with Medicaid data collection, as well as categories that can be compared across data systems and across plans and states.

[8] http://hosted.verticalresponse.com/1027935/98dc1bf217/520801381/b6f64edfca/.

Appeals: We reiterate and incorporate by reference our detailed comments on alignment of appeals, filed in response to the Federal Register announcement at CMS-4182-P.[9] We fully support CMS efforts to create a more unified appeals system for duals.

Medicare Advantage Organizations Crossing Claims Over to Medicaid Agencies

Justice in Aging agrees with CMS that the current system—or more precisely, lack of a system—for handling crossover claims from providers in MA plans creates serious challenges. We have many concerns about how things currently work and their implications for beneficiary access to providers.

Current Issues

Although we know of no published data on how states handle claims by MA plan providers, it appears to us that most states really have no policy at all or, if they do, it is not laid out transparently. We understand that a handful of states give plans capitated amounts to account for the states' QMB payment obligations but do not know if or how any of those amounts are passed to the providers who actually serve the QMBs and are prohibited from collecting co-insurance.

As we read the QMB statutory provisions, the obligation of states to pay deductibles and co-insurance flows to the provider, either directly or indirectly. The loss of deductibles and co-insurance falls on the provider, not the MA plan, and thus it is the provider whose interests are protected by the statute. Thus in our view, it is not enough for states to pay something to MA plans without there being some assurance, whether enforced by CMS or otherwise, that providers be the parties that are ultimately compensated (within the limits of the "lesser of" policy) for their services to QMBs.

Potential Improvements

We believe that implementing an automated crossover process from MA plans to the appropriate Medicaid secondary payer seems more practical and less burdensome than requiring each provider to navigate the system independently.

Our understanding, however, is that currently plans do not have information from the states or from CMS on the identity of the Medicaid plan to which the beneficiary belongs. Thus MA plans would have to rely on the beneficiary for that information, which may not always be accurate. For more reliable records, states would need to institute a process to transmit MCO membership data to MA plans and to update information when an individual changes MCOs.

We think, however, that a cleaner solution would be for all crossover claims to go to one central processing center. As we think more generally about the complexities of crossover claims, including the issues raised by CMS in its proposed revision to 42 C.F.R. 438.3(t),[10] we are becoming increasingly convinced that the most efficient way for states to handle crossover claims is for states to retain within the Medicaid agency the responsibility for processing all crossover claims, whether or not the state

[9] Comments available at www.justiceinaging.org/wp-content/uploads/2018/01/Part-C-and-D-comments-1-16-2018.pdf.

[10] See 83 Fed.Reg. 57264, 57265 (Nov. 12, 2014) available at www.govinfo.gov/content/pkg/FR-2018-11-14/pdf/2018-24626.pdf.

relies on MCOs for delivery of Medicaid services.[11] As we noted in our regulatory comments, payment of crossover claims is purely an accounting function that does not require any determination of medical necessity or any specialized expertise. Delegation to MCOs creates complexities without any tangible added value.

In any case, to fulfill their statutory obligation to process payment claims for QMB services, states have an obligation to create a system that is accessible and functions with reasonable efficiency.

An additional concern, as noted above, is to ensure that the benefits of a state QMB payment system accrue to the providers. This is especially important because providers serving QMBs already face limited remuneration because of the "lesser of" payment policy. Particularly in the managed care context where providers are prohibited from denying service to QMBs, it is important that those providers with a significant number of QMB patients are treated fairly. If they are not, beneficiaries are more likely to experience improper billing or attempts by providers to skirt their obligation to serve QMB plan members.

Thus, though we believe that crossover claims can be processed efficiently if funneled through the MA plan, there also should be safeguards to ensure that providers get the benefit of the state payments and that payments are not just retained by the MA plans. This could be handled in various ways. There could be a simple pass-through from the MA plan of any payment received from the state. Another option could be a capitated payment by the plan to the provider based on the QMB patient population of the provider. Whatever mechanism is chosen, we believe that it is important that CMS ensure that providers ultimately are the ones benefitting from state payments.

Conclusion

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact Amber Christ at achrist@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director

[11] Justice in Aging's comments to the proposal are available at www.justiceinaging.org/wp-content/uploads/2019/01/Justice-in-Aging-Comments-on-Managed-Care-Proposed-Rule.pdf.