JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

October 17, 2018

By electronic delivery to MMCOcomments@cms.hhs.gov

Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Baltimore, MD 21244-8013

Re: Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0

Justice in Aging appreciates the opportunity to respond to the invitation for public comment on the above-referenced proposal submitted to CMS by the Massachusetts Executive Office of Health and Human Services (EOHHS).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. 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, LGBT individuals, and people with limited English proficiency. Justice in Aging has been actively involved in advocacy around the Financial Alignment Initiative (FAI) demonstrations since their inception.

We appreciate that EOHSS is proposing to extend its demonstration. Massachusetts' One Care was the first demonstration to be implemented and, through its development, has introduced many innovative and beneficiary-centered approaches. We are pleased that the state is proposing to continue the program. We also hope that learning from the One Care program will inform and improve the Senior Care Options (SCO) program.

We do, however, have some cautions, concerns and questions about certain details of the 2.0 proposal. We vigorously oppose the unprecedented lock-in and passive enrollment procedures that Massachusetts propose, all of which represent significant erosions in beneficiary rights. We also have concerns that the state is proposing some steps backward from full integration and from a person-centered approach.

We also note that a hallmark of the One Care demonstration has been the active, informed and very insightful participation of the One Care Implementation Council. We urge CMS to look particularly closely to the comments of the Implementation Council and its members. Their on-the-ground experiences and their close monitoring of the successes and challenges of the current demonstration provide valuable insights in how to evaluate the direction of the current 2.0 proposal.

Our comments address the following demonstration requests:

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1. **Flexibility to grow and sustain enrollment in One Care and SCO through passive enrollment and fixed enrollment periods, while expanding both programs state-wide and increasing provider participation**

The EOHHS Proposal: EOHHS is proposing passive enrollment, including passive re-enrollments of individuals who already have opted out in a previous passive enrollment cycle. The state also is proposing an enrollment lock-in that, except for the first 90 days of enrollment, would only permit individuals to leave a plan or change plans annually. We urge CMS to reject this proposal because it curtails the Medicare rights of dual eligibles, is totally contrary to the person-centered goals of the demonstration, creates distrust in the demonstration and confusion among beneficiaries, and is difficult if not impossible to communicate clearly and transparently to beneficiaries.

The numbers: Massachusetts sets out retention rates for its SCO program of slightly under 90% and for One Care of under 70%. In attempting to use the retention rates as justification for additional passive enrollment and for a lock-in, the state claims simultaneously that the retention numbers are "high" indicating beneficiary satisfaction and that passive enrollment and lock-in are nonetheless needed to ensure strong programs. The state also noted "a high degree of member movement between plans in those programs." Those numbers by themselves tell us very little. They do not tell us why beneficiaries stayed or left. These numbers also do not tell us whether plans are meeting or not meeting the needs of their members. They certainly do not justify the extreme measures that the state is proposing. If members are changing plans, the first question should be what about the plan led to member dissatisfaction and how to improve that member experience. A lock-in does not address the failures or delays in plans meeting beneficiary needs. Instead, a lock-in restricts beneficiary choices and leaves them stuck in a plan that may exclude their providers and that they find unsatisfactory.

Passive enrollment: Experience in the financial alignment demonstrations has shown the many problems with passive enrollment, which include: confusing notices; errors resulting both in enrollment of individuals who should not be enrolled and in failure to enroll individuals who qualify for the program; beneficiary distrust of a process that feels coercive; disruption in prescription drug coverage, as well as beneficiary surprise and disruption of care when the beneficiary learns that his provider is not part of the plan network.[1]

As we have argued since the inception of the FAI, we believe that the better approach is to instead direct federal and state efforts into explaining the demonstrations and providing assistance so that the beneficiary can make an informed choice. A program that seeks to be person-centered should start with empowering the beneficiary from the very beginning.

We are especially concerned by the proposal to allow additional rounds of passive enrollment for individuals who previously opted out. When individuals opted out of One Care they had the right to assume that decision would be honored. That right was specifically guaranteed by CMS enrollment guidance.[2] Now the state is claiming that, because it is calling the program 2.0, it can disregard prior

[1] See, e.g., Financial Alignment Initiative: Annual Report: One Care: MassHealth plus Medicare (Sept. 1, 2016), pp. ES-3, and 28, *available at* www.mass.gov/files/documents/2016/10/rg/one-care-annual-evaluation-report-demonstration-year-1.pdf.

[2] Medicare-Medicaid Enrollment and Disenrollment Guidance at 30.2.5(G), *available at* www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPEnrollmentGuidanceManual_CY2019_08022018.pdf.

beneficiary choice. One Care 2.0 is essentially the same program as the original One Care and most of the changes that the state is proposing are behind the scene changes in administration and financing. Those changes simply do not justify another round of passive enrollment for individuals who clearly made their choices known.

To make matters worse, the state is proposing an additional bite at the apple, allowing it to again passively enroll at age 65 an individual who refused One Care enrollment. Thus a 63 year-old person with a disability who refused passive enrollment during the first round of One Care enrollment could be subject to another round of passive enrollment into One Care 2.0, followed in short order with a third round of passive enrollment into SCO. This is the antithesis of putting patients first.

Fixed enrollment periods: On top of this overly aggressive passive enrollment proposal, the state proposes fixed enrollment periods which would lock beneficiaries into their plans for a year, following an initial 90 day disenrollment period. In making this proposal the state references the changes in the Low Income Subsidy (LIS) special enrollment period (SEP) that become effective in 2019. The state's proposal is significantly more restrictive than the LIS SEP, which allows one change each quarter. Thus beneficiaries who join One Care or SCO would be worse off than other Massachusetts low income Medicare beneficiaries with regard to their plan choices. The point of the demonstration is to offer a better experience to beneficiaries, not to penalize them by limiting their rights. Further, we note that the LIS SEP will be in its first year with no track record as to whether it works well for LIS beneficiaries. Approving an even more restrictive lock-in before the LIS SEP changes have even been tested is unwise and unwarranted.

Communicating accurately and effectively about the lock-in also would be particularly difficult. All LIS beneficiaries previously enjoyed a continuous SEP, which was easy for advocates and counselors to explain. In 2019 they will need to understand the new LIS SEP rule changes and, if the state's lock-in proposal were adopted, shortly thereafter dual eligibles participating in the demonstration would face an entirely different set of rules, that would not apply to those outside of the demonstration. Effective written communication to beneficiaries and effective training of advocates and counselors on this complex situation would be extremely difficult and beneficiaries would likely experience significant confusion and disruptions.

Another concern related to the lock-in is that the initial disenrollment period of 90 days coincides with the continuity of care period. Thus individuals may not fully understand that they will lose access to a trusted provider until after they are locked in.

We recognize that the proposal would provide for exceptions to the lock-in if beneficiaries can make certain showings such as that the plan is not meeting the beneficiary's needs. Dual eligibles however are often not well equipped to assert their rights in exceptions processes. Further, they are a group of beneficiaries most likely to have significant changes in their health circumstances. Their need to opt out of the demonstration or switch plans will likely occur at the very time when they are least able to engage in self-advocacy to obtain an exception.

Finally, the lock-in is a change of rules mid-stream for individuals who joined One Care with the explicit understanding that they could leave at any time. In states like California and Ohio, CMS granted waivers of the new LIS SEP to allow those states to keep their promise to enrolled beneficiaries. If Massachusetts wants a waiver of the LIS SEP, it should move in the direction of California and Ohio, to

promote beneficiary flexibility, rather than seeking to take away even more rights from beneficiaries who have enrolled in its demonstrations.

For all these reasons, we ask CMS to deny the lock-in request of Massachusetts and instead encourage the state to seek a waiver that would allow a continuous SEP. Expanding SEP rights, rather than further restricting them, will make the program more attractive to beneficiaries, will ease administration and counseling, and will protect beneficiaries whose needs are not being met by their plan. We further urge CMS to reject the state's proposal to allow beneficiaries to be passively enrolled again. We urge CMS instead to work with the state to move away from passive enrollment altogether to genuinely voluntary enrollment and, further, to develop improved policies and practices that address the issues underlying beneficiary disenrollment decisions.

2. Flexibilities to increase administrative alignment and integration to create a more seamless member experience in each program, building on the approaches used today in One Care

Unified communications: We appreciate that Massachusetts wishes to provide unified communications and materials that speak cohesively about the full scope of each program from the member perspective. Clear unified documents that have been consumer tested and are available in multiple languages and format are essential. We believe it is particularly important for plans to develop mechanisms to ensure that the language and format needs of beneficiaries are captured at the very start of enrollment and that beneficiaries consistently receive communications in their preferred language.

Unified appeals: We urge caution with respect to unifying the appeals system. We appreciate the emphasis on the provision of services pending appeal and believe that this is a critical protection for both Medicare and Medicaid services in the demonstration.

For a consolidated appeal, the state has proposed that all appeals, after review by the plan, go through the state Board of Hearings. This might work well but only if the state undertakes the commitment to training of state ALJs in Medicare law and rules and if CMS has mechanisms to provide assistance and some level of quality control with respect to those decisions. Further, the proposal is silent on what steps would be available for appeals beyond a fair hearing and the path or paths for court access. We urge CMS to work with the state and beneficiary advocates to flesh out more detail on possible integrated appeals procedures and if a more complete proposal can be developed, set it out for further comment. The current proposal merits exploration but is not at a phase where it is ready for approval or implementation.

Complaint Tracking Module: The state also proposes more transparency with respect to grievances filed through the CMS Complaint Tracking Module (CTM). We believe this proposal has merit and will assist in identifying problems that cut across Medicare and Medicaid benefits. It would also allow the ombudsman to be more effective.

Three-way and two-way contracts: We do not fully understand the proposal to have both three-way and two-way contracts with plans. Our initial reaction is to question whether all provisions could be incorporated in the three-way contract so that there will be one unified document with mutual accountability among the state, plans and CMS.

Limitation on Medicaid crossover payment: We have concerns about the proposal to limit the Medicaid wrap to providers. As we understand the proposal, the state wants to require plans to pay providers

less than the full Medicare rate. Plans need to pay providers whatever rate is necessary to attract and retain a robust network. The rate needed may vary based on type of service, location, etc. In some cases, plans may need to pay to full Medicare rate or even higher. In a capitated payment system, it does not seem appropriate to artificially limit the ability of plans to respond to market forces.

3. **To align Medicare financing methodologies and ensure fiscal sustainability for the Commonwealth and federal government by updating One Care to more closely reflect the Medicare financial methodology used in D-SNPs for Parts A/B and Part D services, and implementing a modified Medicare-Medicaid specific Stars methodology**

Financing is the driver of a delivery system. The key and genuinely new characteristic of the FAI has been combined financing of one entity that provides both Medicare and Medicaid services. Getting the exact mix of federal and state payments and savings, setting risk corridors, frailty adjusters and additional factors to work well is an ongoing struggle and much is being learned from the demonstrations. Parts of the Massachusetts proposal appear to be addressing those issues. We are concerned, however, that at its core, the Massachusetts proposal is stepping back from a truly integrated model, seeking to make One Care more like the SCO program, and in doing so, abandoning true integration and moving instead closer to the D-SNP/Medicaid Managed Care model.

We fear that with this move much of the innovation in the One Care model could be in jeopardy. Moving backwards to a model that is more like a traditional D-SNP could endanger the emphasis in One Care on practical implementation of independent living and recovery principles, leading instead to a more medicalized approach that aligns more with Medicare Advantage design. As importantly, the emphasis in the current One Care program on empowering individuals to maximize their opportunities to live fully in the community would not be brought over to the SCO program, resulting in a lost opportunity to bring the innovations of One Care to older adults. We urge CMS to work with Massachusetts to modify its proposal. The state's groundbreaking work in the FAI should not be diluted.

Conclusion

Looking at the Massachusetts proposal as a whole, it appears to us that many of the changes proposed, both in enrollment and financing, are designed with the primary purpose of making it easier to scale up the demonstration, bringing in significantly more beneficiaries and attracting more plan sponsors. We too believe that more Massachusetts dual eligible beneficiaries could benefit from participation in truly integrated plans. We do not believe, however, that growth of the program necessitates erosion of beneficiary rights. Nor do we believe that the very characteristics of the program that have been most beneficial to dual eligibles should to be jettisoned in the interest of growth. We urge CMS to work with Massachusetts to ensure that Massachusetts 2.0 builds on, rather than retreats from, the current demonstration, and results in a program that is more robust than the current program both in beneficiary protections and in program quality for both One Care and SCO programs.

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg
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