March 4, 2016

Sean Cavanaugh
Deputy Administrator, Centers for Medicare and Medicaid Services
Director, Center for Medicare

Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary

Submitted via e-mail to: AdvanceNotice2016@cms.hhs.gov

Re: Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter

Dear Mr. Cavanaugh and Ms. Lazio:

NAMD appreciates the opportunity to provide comments in response to the Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and the 2017 Call Letter.

NAMD is a bipartisan, professional, nonprofit organization representing the Directors of the nation’s 56 state and territorial Medicaid agencies, including the District of Columbia. Among the core areas of focus for NAMD is supporting the work of our members to design, implement and administer person-centered, integrated care programs that provide a more easily navigable and seamless path to all covered Medicare and Medicaid services.

The payment and policy issues contained in the 2017 Advance Notice and Call Letter are increasingly critical to state Medicaid agencies in order to ensure a robust and financially sustainable provider and plan marketplace that can meet the complex service needs of individuals dually eligible for Medicare and Medicaid. NAMD and its members appreciate the rigorous work the Centers for Medicare and Medicaid Services (CMS) has undertaken over the past year to address concerns we and the stakeholder community identified with the Medicare Advantage risk adjustment methodology and Stars Rating system as well as broader alignment work with Dual Eligible Special Needs Plans (D-SNPs) and Medicare Medicaid Plans (MMPs). Updates to these policy and operational issues are necessary to make services more effective and efficient for the dual population.
We also applaud CMS’ plan to enhance administrative flexibilities as well as regulatory changes which will support integration activities, both by D-SNPs and MMPs. Notably, NAMD’s 2015 Operations Survey found that over 20 states are in some form of planning or implementation or have already implemented a D-SNP alignment initiative to drive greater clinical and financial integration for this vulnerable population. We appreciate the commitment that our federal partners at CMS have made to date in this area and we believe this collaboration is having a positive impact on the efficiency of the programs and enrollee experiences.

Still, significant work remains to improve the experience and outcomes for dual eligible individuals and simplify administrative functions. We call your attention to the following key policy issues.

First, we respectfully request that the agency establish equitable enrollment policies for all Medicare beneficiaries, including individuals dually eligible for Medicare and Medicaid. Without question, states believe beneficiaries should be empowered to make choices about the care they receive. In the context of Medicare and Medicaid integration initiatives, many states have implemented policies to ensure there is continuity of care for preferred providers during transitional periods for dual eligible enrollees. However, unlike all other Medicare beneficiaries, dual eligible individuals can change enrollment in managed care plans or churn between Medicare fee-for-service and Medicare Advantage at any point through the year, with or without cause. This authority is wrongly perceived as a beneficiary protection. In fact, the real-world experience reveals this policy is more often disruptive and creates unnecessary challenges to care coordination for providers, plans and members.

States firmly believe that the current policies should be modified to enhance enrollment continuity and break down the unnecessary barriers and challenges that can lead to poor enrollee outcomes and experiences. We respectfully request that CMS work with the Congress and state Medicaid agencies to update enrollment Medicare policies to facilitate improvements in access, quality and payment. In particular, states support the following policy changes, or at a minimum authority, demonstration options to test these concepts:

- Provide only one enrollment period for all Medicare recipients, including dual eligible members. The only exception to that should be dual demonstration enrollment opportunities.
- Provide authority for an enrollment stabilization period for dual eligibles enrolled in D-SNPs and participating in demonstration programs operated in partnership between states and CMS. The ability of dual eligible individuals to change plans at any point – every day, month, etc. – only leads to confusion for them and undermines the goal for care coordination.
Alignment of value-based payment must be bidirectional. We note that a growing number of state Medicaid programs are transitioning to payment methodologies that incent value in the form of high quality, effective and person-centered services. In this context, states are intensely interested in ensuring appropriate alignment in the respective Medicare and Medicaid transitions to alternative, value-based payment arrangements, especially around models that impact the Medicare-Medicaid dual eligible population. Alignment will help incentivize providers to implement innovations that improve care and reduce costs, without which providers may struggle to implement multiple models and fail to realize success. Medicare should be nimble enough to align with Medicaid and commercial APMs where appropriate.

Finally, greater collaboration between CMS and states is necessary to inform how to navigate the separate pathways that have emerged with the MMPs and D-SNPs. States will continue to benefit from further clarity around the integration and alignment options and how these might evolve over time; this will inform their long-term planning and resource allocation.

The remainder of our comments focus on the major issues relevant for states seeking to improve integration through the D-SNP pathway as well as for states participating in the capitated Financial Alignment Initiative (FAI) program. We also highlight Medicare policy changes which may have a downstream impact on Medicaid policy, programming and operations. We submit these comments with the hope that CMS will continue to directly and consistently engage with state Medicaid agencies to work towards a more integrated and aligned system for the beneficiaries we serve jointly.

ADVANCE PAYMENT NOTICE

Section H. CMS-HCC Risk Adjustment Model for CY 2017 (page 27)

We believe the proposal for the 2017 payment year which would update the CMS-Hierarchical Condition Categories (CMS-HCC) risk adjustment model for Medicare Advantage plans appropriately seeks to improve the accuracy of risk-adjustment for full-benefit dual eligibles and disabled individuals, regardless of whether they are enrolled in a Dual-eligible Special Needs Plan (D-SNP) or MMP. States’ experience reflects the findings from CMS’ analysis, namely that on average, dual eligible beneficiaries cost more than non-dual eligible beneficiaries with otherwise similar disease and demographic profiles. States believe the evidence indicates that the update to the CMS-HCC will better reflect the risk plans assume for the dual eligible population and thus afford greater stability in the marketplace for plans serving this vulnerable population.

Recommendations: States strongly support CMS action to finalize the proposal for the 2017 payment year which would update the CMS-HCC risk adjustment model for Medicare
Advantage plans. We appreciate CMS’ consideration of our request to apply this change to Medicare-Medicaid Plans (MMPs) and encourage the agency to also finalize this provision.\(^1\)

Additionally, we ask that CMS confirm that the adjustment to the HCC model can be effectuated without additional data or reporting requirements imposed on states. If this is not the case, we request that CMS engage in further discussions with NAMD and our members to ensure this can be accomplished in an efficient manner.

**Disease Interactions** (pages 33)

NAMD supports CMS’ proposal to include the Psychiatric HCC x Substance Abuse HCC disease interaction for the three community disabled models in 2017 provided it enhances the accuracy of the model.

**2016 DRAFT CALL LETTER**

**D. Impact of Socio-economic and Disability Status on Star Ratings** (page 107)

We continue to believe the Star Ratings system is a helpful tool to measure quality in Medicare Advantage plans. Like Medicare, increasingly state Medicaid programs seek to ensure that they are appropriately incentivizing plans, and providing information that is a true reflection of the performance and experience of the enrollees. As it pertains to the dually eligible population, coordination between Medicare and Medicaid policies is necessary to produce high quality of care and improved health outcomes for this vulnerable population.

We appreciate learning of CMS’s commitment to building the foundation for a long-term solution based on data that show a high percentage of dual eligible (DE) enrollees and/or enrollees who receive a low income subsidy (LIS) limits their plans’ ability to achieve high MA or Part D Star Ratings. We understand CMS’ need to ensure that any policy response must delineate the quality and payment aspects of this issue.

**Recommendations:** While we are supportive of CMS’ proposal to take an interim step to apply the “Categorical Adjustment Index” (CAI) factor, NAMD respectfully seeks additional information from our federal partners on other aspects of this work. Specifically, we ask for your consideration of the following:

- We request that CMS enhance transparency around its plan to monitor the impact of the CAI factor.

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• We ask that CMS consider modifying the CAI based on measures more appropriate to the dual eligible population.
• We request that the agency provide more specificity for a timetable for analyzing available research and developing appropriate, permanent solutions to identified issues.

Transparency of this information can help states better understand opportunities for alignment around quality measurement and payment strategies and anticipate the timetable for such work.

*Star Ratings and Compliance* (page 118 of 2012 Final Rate Notice/Call Letter)

While states share CMS’ goal to hold vendors/plans accountable for performance and have a long track record of doing so, we have two concerns with the CMS policy to automatically downgrade Star Ratings as part of marketing and enrollment sanctions.

First, this policy could have unintended impacts for beneficiaries, especially dual-eligible beneficiaries, as much as it has an impact on plans. The beneficiaries enrolled in plans with higher Star Ratings often receive added benefits and services and reduced cost sharing as a result. Changes in covered benefits and services and reduced cost sharing that are likely in response to downgraded Star Ratings could result in loss of these important services and potential increased cost for Medicaid. CMS also should consider that Medicaid programs could be put in a position to have to fill in the gaps as a result of the changes.

We are also concerned that CMS is considering a similar approach to a Medicaid “Stars-like” rating approach in the Medicaid managed care regulations or other corresponding Medicaid policy. Star Ratings or a similar Medicaid quality rating approach should focus on indicators of performance on a prescribed set of quality indicators, but should not encompass the entirety of a health plan’s compliance with program requirements. A plan can perform well on the prescribed quality indicators, but still have operational compliance issues. In that regard, arbitrarily downgrading a plan’s quality performance for an operational compliance issue unrelated to the quality indicators for which the Star Rating is based fails to provide an accurate picture of performance or elucidate the real concern.

**Recommendation:** We encourage CMS to engage with states regarding approaches that will ensure accountability for plan performance, while minimizing potential negative consequences for beneficiaries and State Medicaid programs.
F. New Measures

1. Care Coordination Measures (Part C) (Page 142)

States believe that care coordination is a vital element of programs which serve dual eligible beneficiaries and other vulnerable populations. State Medicaid agencies, like Medicare, require managed care entities to provide significant care coordination activities for vulnerable populations. Care managers must be able to support, engage and empower beneficiaries in matters related to their care.

However, care managers and efforts to measure care coordination for the dual eligible population are severely hampered by Medicare’s inequitable treatment of these beneficiaries as it relates to their enrollment. Under current policy, at any point in time dual eligible beneficiaries are permitted to opt-in and opt-out of Medicare Advantage plans or to churn between the Medicare Advantage and Medicare fee-for-service program. These are false choices for beneficiaries that are disruptive and undermine care coordination initiatives, and in turn measurement work.

Recommendations: We request that CMS update its enrollment policies to improve care coordination services across the Medicare and Medicaid programs. At a minimum we hope our federal partner will consider how it can address the disconnect between enrollment policy and the vital role of meaningful care coordination services, including through demonstration authority.

Should CMS proceed to expand its work in the care coordination measurement area, we note that meaningful measurement should focus on the actual engagement with the beneficiary and the care manager’s role in the plan of care. Further, effective care coordination should operate across Medicare and Medicaid.

We also acknowledge that this type of measurement is extremely challenging to develop and apply. We believe the federal-state collaborations around the dual eligible population will offer useful insights that may be applicable more broadly.

In keeping with our comments in 2015, we strongly encourage the Center for Medicare and its sister agency partners to collaborate and coordinate around related measurement development efforts under Medicaid and Medicaid Managed Long Term Services and Supports (MLTSS) programs to avoid duplication or conflicts for D-SNPs. This is essential for ongoing alignment efforts and may help minimize conflicts, duplication and excessive measurement and reporting by providers, plans and states.

G. Changes to Existing Star Ratings & Display Measures & Potential Future Change
4. CAHPS measures (Part C & D) (page 146)
As CMS considers and seeks approval for modification to the CAHPS survey, we encourage the agency to consider other issues applicable to the Medicare-Medicaid population. Specifically, state Medicaid agencies have identified the need for more sensitivity to non-English speakers, the lack of proxy methods, and duplication of CAHPS surveys with Medicaid.

**Alternative Payment Models (APMs) (page 173)**

APMs are rapidly becoming the payment paradigm in Medicaid – with approaches ranging from accountable care organizations and health homes to pay-for-performance and bundled payment models. While these models and other APMs like them are taking hold, we recognize that success can be expanded through multi-payer collaboration and thoughtful alignment.

**Recommendation:** As CMS works with Medicare Advantage Organizations to better understand the incentives they employ, we strongly encourage the agency to consider a similar effort with state Medicaid programs. Medicaid programs can serve as a partner to this work and share our learning to drive effective, thoughtful alignment and achieve success.

In particular, NAMD is undertaking a first-of-its-kind analysis to examine value-based purchasing across Medicaid programs. One goal of this report is to understand how state Medicaid strategies align with or differ from activities occurring in Medicare and the commercial insurance market.

Most importantly, the report will provide a thorough picture of innovative Medicaid payment methodologies (i.e., pay for performance, global payments, bundled payments, shared savings and risk), payment components of key delivery system reforms (i.e., patient centered medical homes and health homes), and other value-based purchasing strategies in Medicaid (i.e., health plan assignments based on quality scores). Due to the prominence of managed care delivery models, the analysis will also explore state efforts with managed care organizations (MCOs) to institute value-based purchasing arrangements. Finally, it will examine overarching Medicaid goals and strategies for the move towards value-based purchasing.

This report will be released in March 2016. We believe the study’s findings will have important implications for CMS’ inclusion of Medicaid APMs in the multi-payer component of the incentive program required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
Dual-Eligible Special Needs Plans (page 177)

NAMID is fully supportive of CMS’ proposals to work with states to promote integrated care for Medicare-Medicaid enrollees enrolled in D-SNPs. We appreciate the resources and focus on policies and processes CMS has brought to bear in this area. We encourage CMS to enhance its investment in this work and continue to engage Medicaid agencies on their ideas to enhance the effectiveness of the D-SNP platform.

We welcome immediate action on the issues identified in this section as well as other changes that states and CMS believe offer Medicare-Medicaid enrollees a more seamlessly integrated benefit.

**Recommendations:** We encourage CMS to offer a more flexible approach to administrative issues that arise with states working on dual eligible integration initiatives. We believe this is possible if CMS works with states to focus on the outcome that is desired rather than the process itself.

Regarding administrative materials and notices, states wish to collaborate with CMS to make changes to the Health Risk Assessment to ensure beneficiaries are not subject to multiple assessments. For example, states are interested in exploring with CMS opportunities to leverage information from other assessments to populate the HRA.

States also welcome CMS’ interest in improving marketing materials and model notices to better explain both the Medicare and Medicaid benefits provided by integrated D-SNPs. States wish to ensure that descriptions of benefits in model member materials align with, and meet the approval of, the state Medicaid agency before distribution. Modifications should not result in requirements for additional materials above and beyond the required notices. We believe the experience of the state of Minnesota can serve as a good model for this work.

Additionally, state Medicaid agencies wish to work with CMS to align the information in and requirements for Integrated Denial Notices (IDN). IDNs are an area where state Medicaid agencies often are subject to court orders or state statutes, which are not easily aligned with Medicare’s processes and notifications. Here, states wish to work with Medicare to ensure the beneficiary receives all appropriate information, including Medicare specific information that might otherwise be transmitted in a separate letter to the beneficiary.

**D-SNP Non-Renewals** (page 177)

We welcome the step CMS is taking to provide notice to states in advance of any public announcement regarding nonrenewing or terminating D-SNPs that contract to provide Medicaid benefits to Medicare-Medicaid enrollees in these states. Terminations can
jeopardize market stability, prevent long-term program planning by states and managed care organizations, and disrupt member care. States with high standards of participation in a D-SNP program may face a situation where there are more plans exiting for Stars or Past Performance than are entering the Medicaid managed care program, thus diminishing options for members and creating instability in the D-SNP market.

Recommendation: We also call on CMS to build on the notification proposal. We continue to seek a commitment that CMS will pursue the exercise of its termination authority in direct consultation with the state Medicaid agency when the termination affects a D-SNP. Consultation should include shared decision making on whether to terminate, the timing of termination, beneficiary communications about terminations and coordination on early blocks on enrollment well before December (one month prior to termination). Furthermore, we request that CMS consider D-SNP terminations based on state-specific performance and integrated performance periods, not multi-state contract-level performance or performance periods that predate the integrated product. In order to support state-level goals for Medicare-Medicaid alignment using the D-SNP platform, termination decisions should incorporate state-level performance measures and priorities.

Furthermore, we urge CMS to consider that terminations may require a state to oversee mass migrations from one D-SNP to others, or from the D-SNP program to original Medicaid managed care, on an annual basis. A thoughtful process for terminations that impact D-SNPs, should they occur, is necessary in order to maintain confidence in the platform among policy makers, stakeholders and providers and minimize disruption for enrollees. We strongly recommend, therefore, that CMS consider including state Medicaid agencies in termination planning and final decisions.

D-SNP Model of Care (page 177)

States appreciate CMS’ proposal to conduct joint Model of Care (MOC) reviews with states. The joint review may cross-program understanding of the respective Medicare and Medicaid processes and requirements. We believe states will be interested in this opportunity as capacity allows.

Strengthen the role of the Medicare-Medicaid Coordination Office

We strongly support CMS’ ongoing commitment to the MMCO. In the past year, the MMCO has built on its work to understand and help states navigate policy and operational issues between Medicare and state Medicaid agencies, with the goal of improving the enrollee experience. NAMD shares CMS’ goal to improve the quality of care and general health of Medicare-Medicaid enrollees. We believe the MMCO’s function and expertise will increase in importance as federal and state policymakers – informed by plans and other stakeholders –
work on the issues addressed in the Advance Notice and Call Letter as well as related integration issues.

**Strengthen communication and dialogue with States**

As we have in the past, NAMD encourages CMS to establish and enhance its communication with state Medicaid agencies engaged in integration initiatives. We appreciate the progress that has been made thus far, and urge that CMS continue to make this an area of focus in order to strengthen the federal-state partnership, improve efficiency of operations across government and plan operations, and drive integration and higher quality services Medicare-Medicaid enrollees.

Regular or enhanced communication is needed in two areas: 1) ongoing CMS communication on the status of specific integration proposals from states or plans; and 2) engagement around the learnings and next phases for integration efforts, particularly discussions around the evolution and intersection of D-SNPs, MMPs and the Medicare Advantage program generally.

Thank you for your consideration of our comments. We look forward to continuing to work with you to promote integrated care for the Medicare-Medicaid population towards our shared goals of improving their well-being through efficient, effective use of resources. If NAMD can be of further assistance or facilitate your dialogue with state Medicaid agencies, please do not hesitate to contact Andrea Maresca, NAMD’s Director of Federal Policy and Strategy (andrea.maresca@medicaiddirectors.org).

Sincerely,

Thomas J. Betlach  
Arizona Health Care Cost Containment System Director  
State of Arizona  
President, NAMD

John B. McCarthy  
Director  
Ohio Department of Medicaid  
State of Ohio  
Vice-President, NAMD