



Douglas A. Ducey, Governor
Thomas J. Betlach, Director

January 16, 2018

Mr. Demetrios Kouzoukas
Director
Center for Medicare
United States Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted by e-mail to: <http://www.regulations.gov>

RE: Notice of Proposed Rulemaking (NPRM) CMS-4182-P, Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Programs, and the PACE Program

Dear Director Kouzoukas:

The Arizona Health Care Cost Containment System (AHCCCS) appreciates this opportunity to comment in response to the Centers for Medicare & Medicaid Services' (CMS') Notice of Proposed Rulemaking (NPRM) CMS-4182-P: *Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Programs, and the PACE Program* as released on November 16, 2017.

AHCCCS, Arizona's single state Medicaid agency, provides health care coverage to the State's acute and long-term care Medicaid populations, including approximately 159,000 dual eligible beneficiaries. Since 1982, when it became the first statewide Medicaid managed care system in the United States, AHCCCS has operated under a federal 1115 Research and Demonstration Waiver that allows for the operation of a total managed care model. AHCCCS continues to pursue strategies that better align health service delivery by reducing fragmentation and increasing system alignment and integration. Arizona has achieved integration for dual eligible beneficiaries through the Medicare Advantage Dual Special Needs Plan (D-SNP) model. AHCCCS requires all Medicaid contracted managed care organizations to also be D-SNPs. This requirement offers dual eligible beneficiaries the opportunity to align all Medicaid and Medicare service coordination through one managed care organization, resulting in meaningful improvements in the health of this fragile population.

Arizona's Success of Integrating Care for Dual Eligible Beneficiaries

Through careful, incremental strategies, Arizona has achieved alignment (defined as beneficiaries enrolled in the same health organization for both Medicare and Medicaid services) for approximately 41 percent of all dual eligible beneficiaries through the ongoing success of its adopted D-SNP model. This represents approximately 65,000 dual eligible beneficiaries statewide. The D-SNP model has given Arizona the ability to align incentives that drive health plan performance and support alignment efforts to better coordinate care for dual eligible beneficiaries, and has contributed to AHCCCS as a nationwide model of success.

A study conducted by the consulting firm Avalere illustrates the success of AHCCCS' integrated care initiatives in achieving improved health outcomes on behalf of dual eligible beneficiaries. Findings as compared to Original Medicare include:

- 3 percent increased proportion of beneficiaries accessing preventive health services,
- 9 percent lower rate of emergency department visits,
- 43 percent lower rate of days spent in the hospital (inpatient utilization),
- 19 percent lower average length of stay (inpatient utilization),
- 21 percent lower hospital readmission rate.

Further details regarding AHCCCS' success in coordinating integrated care as identified by the Avalere study, *Analysis of Care Coordination Outcomes /A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries* can be found at http://avalere.com/research/docs/20120627_Avalere_Mercy_Care_White_Paper.pdf.

Other states pursuing integrated care models also report successes in achieving improved health outcomes. As compared to the Medicaid-only Minnesota Senior Care Plus program, the state's alternative, integrated Senior Health Options program for dual eligible beneficiaries reports that its participants:

- Were 2.7 times more likely to have a primary care visit,
- Had 6 percent lower rate of outpatient emergency department visits,
- Had 26 percent fewer hospital stays,
- Had 36 percent fewer specialist visits,
- Were 13 percent more likely to receive any home and community based services (HCBS) visit.

Further details regarding the successes of Minnesota's Health Options program can be found in *Minnesota Managed Care Longitudinal Data Analysis* at <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.

These examples illustrate how integrated care coordination on behalf of dual eligible beneficiaries not only improves their health outcomes, but can also positively bend the health care delivery cost curve, to slow the rate of spending growth that provides states with the ability to further serve high acuity populations within existing resources.

It is within these contexts of improving health outcomes on behalf of dual eligible populations, and enhancing the capabilities of states to positively reduce health care delivery costs through the promotion of integrated care – as illustrated by Arizona's more than a decade of experience through collaboration with its MA D-SNP partners – that AHCCCS respectfully submits its following comments to this NPRM for CMS' consideration.

II.A.1. Implementation of the Comprehensive Addiction and Recovery Act of 2018 (“CARA”)

AHCCCS fully supports CMS' proposal as described to implement these provisions of CARA. While dual eligible beneficiaries may be a small proportion of the total population proposed to participate in these updated activities, AHCCCS wishes to reinforce to CMS that strengthening continuity of care, and the communication capabilities and capacities of participating stakeholders' on a beneficiary's multi-disciplinary care team, are each key to promoting the desired outcomes of reduced opioid usage and increased usage of available alternative therapies. Such coordination and contact with a participating dual eligible beneficiary is essential for those identified in potentially high-risk subpopulations, such as the seriously mentally ill, the homeless, veterans, and others with multiple chronic co-morbidities. Giving a Medicare Advantage Organization's (MAO's) multi-disciplinary care teams the latitude to develop

unique solutions to a beneficiary's presenting conditions will make a difference in health outcomes achieved, as well as demonstrating the effectiveness of the program.

II.A.2. Flexibility in the Medicare Advantage Uniformity Requirements

II.A.6. Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review

In its consideration of modifying or reducing uniformity requirements, and eliminating meaningful difference requirements of MAO offered plan benefit packages, AHCCCS requests that CMS take into account, in further consultation with states, how such proposed changes may impact:

- State Medicaid Agency expectations and contract requirements for uniform plan benefit designs to be offered on behalf of dual eligible beneficiaries statewide across multiple geographies (urban, rural, frontier),
- Provider network design/accessibility by provider type (e.g., hospitals, SNFs, specialists, etc.),
- Premium and cost sharing amounts,
- Other integrated care requirements that may be included in Medicaid managed care organization (MCO) and companion MAO D-SNP state-contracted MIPPA Agreements.

II.A.7. Coordination of Enrollment and Disenrollment Through MA Organizations

AHCCCS fully supports CMS' proposal to permit state optional default enrollment of newly identified dual eligible beneficiaries directly into the companion Medicare Advantage D-SNP of their current Medicaid MCO, using the requirements from existing guidance to be promoted to rule.

Since CMS' approvals of default enrollment in 2016, AHCCCS' contracted Medicaid MCOs have successfully enrolled approximately 7,000 newly dual eligible beneficiaries into their respective companion MA D-SNPs on the beneficiaries' Medicare effective date, with a retention rate of greater than 85 percent. Complaints, grievances and appeals as received by the participating MA D-SNPs to date are de minimis.

Beneficiary choice protections are maintained in the proposed default enrollment process. The proposed process is consistent with established operating protocols that include timely D-SNP prior notifications, contact opportunities, and opt-out and rapid disenrollment capabilities both prior to and subsequent from the beneficiary's Medicare effective date.

While AHCCCS is supportive of CMS' proposal to permit state optional default enrollment, CMS' proposed alternative to permit a simplified opt-in process is cause for concern, as it would create additional confusion on behalf of dual eligible beneficiaries regarding the process, reduce initial access to the benefits of integrated care, and potentially delay use of the D-SNP as his/her Single Point of Contact (SPOC) for subsequent successful navigation of the health care delivery system, while also posing additional administrative burden to the D-SNPs in completing the process. AHCCCS respectfully requests that this alternative not apply or be available as an option for use in default enrollment as administered by CMS and state-approved Medicaid MCO companion D-SNPs.

In regards to existing default enrollment guidance, specifically the requirement that the MAOs identify the potential new dual eligible beneficiary no less than 90-days prior to their Medicare effective date, AHCCCS requests that CMS consider combining this requirement with the eligibility verification requirement of 60-days prior to a beneficiary's Medicare effective date. The primary action carried out by D-SNPs to accomplish, in addition to identification and verification of dual eligibility, is the notification to the prospective newly dual eligible beneficiary no less than 60-days prior to their Medicare

effective date. The activities implemented by D-SNPs prior to this notification do not directly affect the potential new dual eligible; in fact, if dual eligibility is not confirmed, the beneficiary is not contacted, nor is the default enrollment process initiated for such an individual.

Combining the 90-day identification and 60-day eligibility verification periods would provide D-SNPs with enhanced opportunities to identify and verify potential newly dual eligible candidates based on further Medicare eligibility information that may be received during the 90-day to 60-day window prior to the beneficiary's Medicare effective date, which would be beneficial to both the aging-in and disabled populations. Furthermore, an enhanced identification and eligibility verification period would still conform with other existing default enrollment requirements, such as the notification to the beneficiary by no later than 60-days prior to their Medicare effective date, and the established window for the opt out period which is zero- to 60-days prior to the beneficiary's Medicare effective date.

AHCCCS believes that providing the Medicaid MCO companion MA D-SNPs with this further flexibility to identify and verify potential newly dual eligible eligibility through the default enrollment process further enhances both states' and CMS' goals and initiatives to promote continuity of care for dual eligible beneficiaries within existing beneficiary protections and choice options.

Regarding the proposed duration of CMS approval of the default enrollment process to an MAO, AHCCCS recommends a 5-year approval period. AHCCCS believes that in establishing a 5-year approval, CMS should review a baseline of default enrollment outcome data over time as measured against defined criteria; if a D-SNP meets these criteria, then a 5-year streamlined extension should be granted. If default enrollment complaint, grievance and retention rates justify further oversight activities on behalf of a participating MAO during a 5-year approval period, then a CMS MA Account Manager currently has appropriate administrative tools and actions available through the *Medicare Advantage Managed Care Manual* enrollment and disenrollment provisions to effect necessary remedies as circumstances may warrant.

AHCCCS believes that promoting continuity of care on behalf of dual eligible beneficiaries through integrated care models, and use of integrated administrative tools such as default enrollment will provide cost savings to the Medicare program as a result of reduced MAO administrative costs when the beneficiary is enrolled in health plans sponsored by the same parent organization. Such cost savings will occur by not requiring resources to be incurred to subsequently coordinate care with a third party MAO or non-companion Medicaid MCO. When participating MAOs each meet state contracting requirements for D-SNP benefits to be effectively similar in design and components (with few meaningful differences and uniformity), and as approved by CMS, then dual eligible beneficiaries will not have additional premium costs or cost sharing obligations than if enrolled in Original Medicare.

Given the current seamless conversion (default) enrollment application moratorium currently in place, AHCCCS requests CMS give due consideration to finalizing this provision of the NPRM as soon as practicable in order to address those circumstances where state Medicaid-contracted new or existing MAO D-SNPs with new or expanded service areas (counties) effective January 1, 2018 may submit, complete and obtain necessary approvals to implement this process.

The collaboration of our participating stakeholders, including CMS, in establishing default enrollment on behalf of Arizona's dual eligible beneficiaries has advanced the provision of integrated care coordination for beneficiaries, while maintaining critical beneficiary protections and choice options.

II.A.8. Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Duals

AHCCCS appreciates CMS' timely recognition of this issue and fully supports this proposal, and highlights these components:

- Promotion of continuity of care for dual eligible beneficiaries between their Medicaid MCO and companion MA D-SNP (alignment),
- CMS consultation and collaboration with states so that the MA D-SNP transition is effectively coordinated with a dual eligible beneficiary's change in Medicaid MCO, as necessary, and
- Flexibility in working with states so that this process maintains alignment between a dual eligible beneficiary's new Medicaid MCO and resultant switch to a new MA D-SNP in the most seamless and least confusing manner possible.

AHCCCS believes that promoting continuity of care on behalf of dual eligible beneficiaries through integrated care models and using integrated administrative tools such as passive enrollment as proposed here will provide cost savings to the Medicare program stemming from reduced MAO administrative costs when the beneficiary is enrolled in health plans sponsored by the same parent organization, thereby not requiring resources to be incurred to subsequently coordinate care with a third party MAO or non-companion Medicaid MCO.

II.A.10. Establishing Limitations for the Part D Special Election Period (SEP) for Duals

AHCCCS fully supports CMS' proposal as described to establish limitations on the current continuous Special Election Period (SEP) available to dual eligible beneficiaries. CMS' preamble discussion to this proposal provides a sound basis for such a limitation. The limitation proposed and this provision's applicability to integrated Medicare Advantage-Part D plans also supports CMS' objectives for addressing potentially at-risk and at-risk opioid users as outlined in section II.A.1 of this NPRM.

AHCCCS' and other state Medicaid agencies have previously requested that the concept of limiting dual eligible beneficiaries' opportunities be considered and implemented to support CMS' continuity of care and integrated care objectives, while at the same time to reduce the potential of additional administrative costs to Medicare Advantage and participating MAOs as a result of enrollment churn.

In supporting this proposal, AHCCCS recognizes CMS' ongoing commitment to SEPs as a beneficiary protection tool to effectively address various Medicare Advantage administrative situations when needed as applicable and appropriate, as well as providing dual eligible beneficiaries with an additional one time "choice" election period available any time each calendar year. AHCCCS believes that this carefully considered data- and experience-based proposal will meet CMS' objectives and effectively address stakeholders' concerns by permitting dual eligible beneficiaries with up to potentially four SEP opportunities per year as circumstances warrant.

II.A.11. Medicare Advantage and Part D Prescription Drug Plan Quality Rating System

AHCCCS concurs with CMS' proposal to codify Star quality rating system metrics in rule. Over time, this will reduce the potential for confusion as to whether specific metrics are included or excluded in the data set as promulgated through the annual Call Letter process. Year-over-year metric and measurement methodologies are important in determining and communicating final results for use by the ultimate decision-makers, beneficiaries. However, AHCCCS requests, as it has in the past, that CMS continue to consider and revise Star metrics and metric risk adjustment evaluation methodologies where appropriate, in consultation with state Medicaid agencies, that may skew individual metric results for state-contracted MA D-SNPs as a result of the increased health acuties and chronic conditions of their enrolled dual eligible beneficiaries, as compared to other non-special needs plan Medicare Advantage plans.

In response to multiple CMS requests for public comment regarding Star metrics and methodologies, AHCCCS has previously provided comments on these issues/topics to address concerns directly pertaining to D-SNP metrics and evaluation methodologies:

- Abundant evidence has been reported in the risk adjustment literature that the MA risk adjustment methodology “under” predicts costs for certain high-cost/high-risk beneficiaries and “under” values” the costs of caring for full benefit dual eligible beneficiaries enrolled in D-SNPs relative to non-dual eligible beneficiaries’ costs when enrolled in traditional Medicare. AHCCCS shares CMS’ goal to improve the quality of care and general health of dual eligible beneficiaries, yet continues to be concerned that the needs of these high-risk/high-need dual eligible beneficiaries (the highest cost, frailest and fastest growing Medicare subgroup) — and the care management activities of D-SNPs to address them — are not fully represented in the Star quality rating system.
- AHCCCS continues to support CMS’ commitment to building a long-term solution which is reflective of data demonstrating that a high percentage of dual eligible beneficiaries limits D-SNPs’ ability to achieve higher Part C or Part D Star rating scores. Like Medicare, AHCCCS seeks to ensure that its contracted D-SNPs are appropriately incentivized, and identify valid data that truly reflects the experience of dual eligible beneficiaries enrolled in those contracted D-SNPs. Without valid metrics applicable and appropriate to enrolled dual eligible beneficiaries, continued coordination between, and further enhancement of, Medicare and Medicaid policies remains a priority in order to produce high quality of care and improved health outcomes for this vulnerable population.
- AHCCCS also continues to support the ongoing increased attention CMS has placed on the recognition on how Medicare beneficiaries’ socio-economic statuses (SES) and social determinants of health (SDH) impact Star ratings scores of D-SNPs serving disproportionate shares of dual eligible beneficiaries who are frail elderly, or those with severe disabilities and complex conditions. AHCCCS has previously commended CMS on undertaking initiatives to address and revise Star quality system methodologies to account for this impact. AHCCCS has also strongly supported, and continues to support, CMS’ efforts to address reducing the disparities in the quality of care for high risk and low income dual eligible beneficiaries. In doing so, AHCCCS reiterates the importance that CMS must continue to recognize the additional effort and resources required by D-SNPs, and other participating stakeholders, to achieve population health improvements for groups such as dual eligible beneficiaries that face multiple, and ongoing disadvantages in navigating the health delivery system.
- Like Medicare, AHCCCS requires that it’s contracted Medicaid MCOs to engage in significant care coordination activities for enrolled vulnerable populations such as dual eligible beneficiaries. In measuring such care coordination activities, AHCCCS continues to strongly encourage CMS and its sister agency partners to collaborate and coordinate around similar and related measurement development efforts for Medicaid Managed Long Term Services and Supports (MLTSS) programs, and to participate in future initiatives sponsored by the National Committee for Quality Assurance (NCQA) to develop MLTSS metrics and measures reduce or avoid data collection and evaluation duplication, data conflicts, and/or excessive measurement and reporting activities to be undertaken by participating stakeholders, including, but not limited to providers, D-SNPs and states. MLTSS metrics development and enhancement, taking into account D-SNP population characteristics and mission, remains essential for ongoing health delivery system alignment efforts on behalf of dual eligible beneficiaries.

- Regarding CMS' ongoing efforts to further Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures enhancements in addressing the needs of dual eligible beneficiaries, AHCCCS and other state Medicaid agencies note the need for more sensitivity to non-English speakers, the lack of proxy methods, and duplication of CAHPS surveys with Medicaid. AHCCCS remains concerned that continued reliance on self-reported data, which can be difficult for frail elderly and severely disabled dual eligible beneficiaries to report accurately, can potentially lead to skewed results that ultimately place the validity of such self-reported data in question. Use of submitted claims data, with appropriate adjustments, can provide CMS and stakeholders with increased data validity for application and use in Star quality metric scoring methodologies and evaluations.

AHCCCS appreciates CMS' ongoing commitment to date, and strongly supports CMS' continuing joint efforts, through collaborative engagement with states, to appropriately address and revise Star metrics, risk adjustment criteria and evaluation methodologies as part of enhancing the value of Star data and scores on behalf of all stakeholders, including dual eligible beneficiaries and participating D-SNPs.

AHCCCS fully expects that CMS' ongoing commitment to enhancing the Star criteria and process will continue subsequent to codifying Star quality rating system methodologies in rule.

II.A.17. Request for Information Regarding the Application of Manufacturer Rebates and Rx Price Concessions at the Point of Sale (POS)

In best designing strategies to provide dual eligible beneficiaries with improved prescription pricing transparency at the POS, AHCCCS requests at a minimum that CMS further consults with states during its review regarding the potential impact specific to dual eligible beneficiaries.

II.B.1. Restoration of the Medicare Advantage Open Enrollment Period

In its consideration of the proposal to restore the Medicare Advantage Open Enrollment Period as required by CARA, AHCCCS requests that CMS take into account and address, in consultation with states, any potential impacts to D-SNP and FIDE D-SNP enrollment vis-a-vis our shared continuity of care objective for dual eligible beneficiaries.

II.B.10. Part D Prescriber Preclusion List

II.B.11. Part C/Medicare Advantage, Cost Plan and PACE Preclusion List

In its consideration of the proposal to implement respective Part C and Part D program Preclusion Lists in lieu of direct registration of participating Medicare providers with CMS, AHCCCS requests that CMS take into account, in further consultation with states, how such proposed changes may impact states given that currently:

- State Medicaid programs use Medicare provider registration data as part of their respective Medicaid provider database and registration requirements,
- Various agencies in the states use Medicare certification of particular provider types as part of respective provider licensure and registration requirements (e.g., home health agencies, hospice),
- States do not provisionally address provider circumstances of "behavior that could result in revocations" as proposed (*emphasis added*), and how such circumstances may be addressed differently by provider type,
- Provider registration with state Medicaid agencies may act or may be considered in large part to be sufficient in representing effective and valid Medicare program registration by proxy, outside of any additional CMS provider preclusion list development, which also may be coordinated with the states.

II.B.12. Removal of Quality Improvement Project (QIP) for Medicare Advantage Organizations (MAOs)
In its consideration of eliminating the QIP requirement for MAOs, AHCCCS requests that CMS take into account, in further consultation with states, how such proposed changes may impact state EQRO evaluation activities that currently implement the optional use of MAO QIP reports as part of annual reviews, as permitted by 42 CFR 438.360: Nonduplication of Mandatory Activities with Medicare or Accreditation Review.

Conclusion

AHCCCS welcomes CMS' immediate actions to advance those enhancements to D-SNPs that can offer dual eligible beneficiaries a more seamless integrated set of coordinated health care benefits. In doing so, CMS will continue to support the ongoing viability of the D-SNP model, the foundation of AHCCCS' success in integrating care for the state's most vulnerable populations.

AHCCCS fully supports CMS' ongoing interest, focus and resources dedicated resources to advancing policy for dual eligible beneficiaries and its commitment to strengthening the role of D-SNPs as a platform for health integration.

AHCCCS looks forward to continuing to work with CMS and other participating stakeholders to promote integrated care for dual eligible beneficiaries.

Sincerely,



Thomas J. Betlach
Director

cc: Tim Engelhardt, Director, Medicare-Medicaid Coordination Office (MMCO), CMS
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