April 6, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-4190-P Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Administrator Verma:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 85 Fed. Reg. 9002 (February 18, 2020).

Over the past six months, the Commission has engaged in many conversations regarding integrated care programs for individuals dually eligible for Medicare and Medicaid, including hearing directly from stakeholders and analyzing the availability of integrated care models. In the Commission's view, increasing the availability of integrated care programs and the number of dually eligible beneficiaries enrolled in such programs has the potential to improve beneficiary care and promotes more effective and efficient coordination between Medicaid and Medicare. We expect our work on integrated care will be a multiyear process resulting in recommendations and analyses that can inform federal and state policies.

The Commission discussed this proposed rule at our February 28, 2020 public meeting, as it would make a number of policy changes relevant to integrated care programs that are of interest to us. In particular, it would restrict dual-eligible special needs plan (D-SNP) look-alike plan offerings. In our December

2018 comment letter on proposed Medicare Advantage (MA) regulations, the Commission expressed its concern that D-SNP look-alike plan growth may undermine integrated care efforts by drawing dually eligible beneficiaries away from integrated products (MACPAC 2018). At that time, we urged CMS to monitor the growth of look-alike plans, identify their potential effects on integration efforts, and determine if further action needed to be taken either by the agency or Congress. We support CMS's proposal to restrict D-SNP look-alike plans; at the same time, we urge CMS to continue monitoring this issue. In particular, we suggest that you pay particular attention to the set of plans with enrollment of dually eligible beneficiaries between 50 and 80 percent of total enrollment.

Several other provisions would also support state use of D-SNPs in integrated care models by potentially expanding access to D-SNPs in rural areas, strengthening care management requirements, and implementing new flexibility in supplemental benefits. We expand on these issues below.

Restricting D-SNP Look-Alike Plans

In recent months, the Commission has engaged in two areas of work on D-SNP look-alike plans that inform our comments on CMS's proposal: an analysis of D-SNP look-alike availability and stakeholder interviews.

MACPAC estimates of D-SNP look-alike availability

We analyzed MA bid data, using the projected member months to estimate full-year equivalent enrollees. For comparability with prior analyses conducted by the Medicare Payment Advisory Commission, we focused on plans with enrollment of dually eligible beneficiaries at the 50 percent and 80 percent threshold (MedPAC 2019). We found that the number of traditional MA plans that projected their enrollment would be over 50 percent dually eligible beneficiaries increased from 94 in 2019 to 98 in 2020 (Table 1). While this is not a large increase in the number of plans overall, enrollment in these plans is growing substantially. Total enrollment in these plans in 2020 was projected to be 271,080—about 23.4 percent higher than enrollment in such plans in 2019. This far exceeded the growth in enrollment in D-SNPs, which was only 13.9 percent. The projected number of plans with dually eligible beneficiaries accounting for over 80 or 90 percent of enrollment also increased over this time period, but projected total enrollment in these plans somewhat declined.

TABLE 1. Availability of and Projected Total Enrollment in Medicare Advantage Plan Types, 2019 and 2020

Plan type	Number of states where available		Number of plans			Projected total enrollment		
	2019	2020	2019	2020	Percent change	2019	2020	Percent change
Dual-eligible special needs plans	43	43	458	532	16.2%	2,363,748	2,691,834	13.9%
Institutional special needs plans	40	45	125	150	20.0	90,102	116,360	29.1
Chronic condition special needs plans	28	30	117	158	35.0	357,139	348,777	-2.3
D-SNP look-alike plans: More than 50 percent of enrollees are dually eligible beneficiaries	35	28	94	98	4.3	219,610	271,080	23.4
D-SNP look-alike plans: More than 80 percent of enrollees are dually eligible beneficiaries	13	22	54	66	22.2	193,483	182,561	-5.6
D-SNP look-alike plans: More than 90 percent of enrollees are dually eligible beneficiaries	11	18	35	44	25.7	66,231	62,479	-5.7
Other MA plans: 50 percent or less of enrollees are dually eligible beneficiaries	50	50	2,590	3,019	16.6	13,903,562	14,975,308	7.7

Notes: D-SNP is dual eligible special needs plan. MA is Medicare Advantage. Figures exclude plans that do not provide drug coverage, employer plans, cost plans, Medical Savings Account plans, and plans that only operate in Puerto Rico. Total enrollment includes dually eligible and Medicare-only beneficiaries. Dually eligible beneficiaries include both full-benefit and partial-benefit dually eligible beneficiaries. Data undercount projected enrollment of dually eligible beneficiaries due to how certain beneficiaries are classified in bid data; thus the number of D-SNP look-alike plans may be undercounted.

Source: MACPAC, 2020, analysis of 2019 and 2020 Medicare Advantage bid data from the Centers for Medicare & Medicaid Services.

The state with the most look-alike plans in 2020 is California, with 40, followed by 6 in Florida and Illinois. Of the 98 D-SNP look-alike plans offered in 2020, 14 (14.3 percent) are offered in states that do not have D-SNPs. States with multiple D-SNP look-alike plans include Arizona and Virginia, which have integrated care programs. However, look-alike plans are also present in several states that do not have integrated care programs but where D-SNPs are available, including Connecticut and Mississippi.

Findings from stakeholder interviews

To assess how changes in the MA market—including D-SNP look-alike plans—are affecting integrated care programs, we contracted with RTI International and the Center for Health Care Strategies to conduct a literature review and 17 stakeholder interviews. Interviewees included federal officials, state officials and consultants, health plan representatives, provider representatives, and beneficiary advocates. Interviews were conducted from October 2019 to January 2020.

Among the findings of this work was stakeholders' concern that state decisions to either limit D-SNP contracting to promote integrated care efforts or not contract with D-SNPs at all have been a catalyst for D-SNP look-alike plan growth. Increasing federal requirements for D-SNPs, such as those implementing provisions of the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123), may also encourage D-SNP look-alike plan growth. Interviewees also indicated that compensated agents and brokers and misleading marketing practices play a role in influencing beneficiary decision making about enrollment in D-SNP look-alike plans. Stakeholders raised concerns that D-SNP look-alike plans have affected enrollment in integrated care programs. In particular, stakeholders cited policies implemented by the state of California to encourage enrollment in the Financial Alignment Initiative (FAI) demonstration as being a major impetus for D-SNP look-alike plan growth in the state, which actually led to decreased enrollment in the demonstration.

Comments on proposed rule

In the Commission's view, look-alike plans act at cross purposes to both state and federal efforts to promote integration by drawing beneficiaries away from integrated models. While this may be less of a concern in states that do not have managed long-term services and supports (MLTSS) programs or are not participating in the FAI, the phenomenon may affect state willingness to pursue such strategies.

In the proposed rule, CMS proposes to stop contracting with traditional MA plans in which dually eligible beneficiaries comprise 80 percent or more of total enrollees, if those plans are located in states where D-SNPs or another plan authorized by CMS to exclusively enroll dually eligible beneficiaries are available. The Commission considers this proposal to be a useful starting point in reducing the potentially harmful effects of D-SNP look-alike plan growth on integrated care programs.

However, the Commission is concerned that while the proposal would address the most egregious instances, there is still a real risk that we will see growth in look-alike plans falling below the 80 percent threshold and thus continuing to detract from federal and state efforts to improve integration of care. Our analysis shows that from 2019 to 2020, enrollment growth in dually eligible beneficiary enrollment in look-alike plans was most notable in plans that were over a 50 percent threshold. About 88,500 beneficiaries were in D-SNP look-alike plans that were comprised of more than 50 but not over 80 percent dually eligible beneficiaries (about one-third of D-SNP look-alike plan enrollment).

It is important to note that in six states with D-SNP look-alike plans, no plans would meet CMS's proposed threshold: Alabama, Connecticut, Florida, Kansas, Oklahoma, and Virginia. In all of these states, there are plans in which dually eligible beneficiaries are projected to comprise over 50 percent of total enrollees. It is also important to note that both Florida and Virginia have both MLTSS and D-SNPs, and are considered to either partially (Florida) or fully (Virginia) align the two products (Kruse and Soper 2020). Thus CMS's proposal would not prohibit enrollment of dually eligible beneficiaries in the six plans in Florida or three plans in Virginia that compete with D-SNPs.

The Commission is not recommending that CMS set a lower threshold at this time, but strongly suggests that CMS monitor how plans respond if the 80 percent threshold is finalized. CMS should closely monitor whether D-SNP look-alike plans are able to keep dually eligible beneficiary enrollment just below the 80 percent threshold, and determine whether this threshold is low enough to mitigate the effects of look-alike plans on integrated care programs. If plans are able to stay just below the 80 percent threshold, or if evidence shows that look-alike plans with lower levels of enrollment by dually eligible beneficiaries negatively affect integrated care programs, CMS may need to further reduce the threshold. CMS should also monitor trends in look-alike plan enrollment among full- and partial-benefit dually eligible beneficiaries, and consider whether policies related to look-alike plans should differentiate between those groups. At a minimum, CMS should clarify in the final rule whether this policy includes partial-benefit dually eligible beneficiaries enrolled in D-SNP look-alike plans.

Changes to Network Adequacy Requirements

In the Commission's discussion of integrated models we have noted that D-SNPs are not available in many rural areas. Where states are already offering MLTSS programs statewide, this limits the ability to advance integration by combining MLTSS with D-SNPs.

While a number of factors may affect plan interest in offering D-SNPs in rural areas, in this rule, CMS proposes changes to network adequacy requirements that could allow more MA plans, including D-SNPs, to be offered in rural areas. CMS's proposal to adjust its network adequacy standards in counties designated as micro, rural, or having extreme access considerations, could result in greater D-SNP availability. We are unable to fully assess the extent to which D-SNP growth will be spurred by requiring that 85 percent of beneficiaries rather than 90 percent of beneficiaries have access to at least one of certain specialty providers or facilities within published maximum time and distance standards, and adding additional credit for plans that use telehealth for certain specialties. However, the Commission considers this proposed change as a move in the right direction. In the future, the Commission also intends to explore other areas where D-SNP network adequacy requirements might be refined to better reflect individual state circumstances.

Care Management and Model of Care Requirements

The Commission is generally in support of CMS's proposals to implement care management and model of care requirements mandated by BBA 2018 for chronic condition special needs plans and extend them to D-SNPs. However, we draw attention to some proposed requirements (e.g., an annual face-to-face visit) that may overlap with requirements for MLTSS contractors. In addition, states are increasingly weighing in on D-SNP models of care as part of the contracting process. Thus, the Commission asks CMS to be mindful of how the prescriptiveness of federal requirements might affect states' ability to tailor D-SNP contracts as part of their integrated care efforts.

Special Supplemental Benefits for the Chronically Ill

BBA 2018 allowed MA plans to provide additional supplemental benefits to chronically ill enrollees, referred to as special supplemental benefits for the chronically ill (SSBCI). SSBCI can include a wide range of non-primarily health-related benefits such as food and produce, pest control, and structural home modifications (CMS 2019). The Commission has begun monitoring how MA plans, including D-SNPs, take up this new flexibility. While we have some concern these benefits could be used to attract beneficiaries away from integrated care plans, they also have potential to augment integrated care programs by allowing D-SNPs to offer new benefits. Thus, the Commission asks CMS to likewise monitor any effects of the new SSBCI authority on integrated care programs.

Again, we appreciate the opportunity to provide comments on this proposed regulation.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Chuck Grassley, Chair, Senate Finance Committee
The Honorable Ron Wyden, Ranking Member, Senate Finance Committee
The Honorable Frank Pallone, Chair, House Energy and Commerce Committee
The Honorable Greg Walden, Ranking Member, House Energy and Commerce Committee

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