



July 15, 2008

**VIA ELECTRONIC MAIL**

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
ATTN: CMS-4131-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: 73 Federal Register 28566 (May 16, 2008); Proposed Changes to Part 422 – Medicare Advantage Program**

Dear Sir/Madam:

We appreciate this opportunity to comment on proposed rules for the Medicare Advantage program, CMS-4131-P. Our comments will be limited to provisions related to Special Needs Plans (SNPs), with particular attention paid to SNPs that target consumers who are dually eligible for Medicare and Medicaid.

Community Catalyst is a national nonprofit advocacy organization dedicated to achieving quality, affordable health care for all. Since 1997, we have been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, we work in partnership with national, state, and local consumer organizations, policymakers, and foundations to provide leadership and support needed to ensure that the health care system serves everyone—especially vulnerable members of society. In 2006, we partnered with the Commonwealth Care Alliance, a SNP serving dually eligible beneficiaries in Massachusetts, to create the Special Needs Plan Consumer Education Project. Our goal is to educate state and federal policymakers, health care providers, and the public about the risks and opportunities presented by SNPs; work with consumers to identify and promote SNP best practices; and strengthen the consumer voice on policy issues related to SNPs.

We believe that well-designed and well-administered SNPs have the potential to deliver high-quality care to the sickest, most vulnerable members of the Medicare population. This is especially true where SNPs serve as the vehicle for Medicare and Medicaid integration, preserving entitlement to the full benefits of both programs while tailoring the benefits and services they offer to the unique needs of their enrollees. In February 2008, we published “Medicare Special Needs Plans: A Consumer Advocate’s Guide to Opportunities, Risks, and Promising Practices.”<sup>1</sup> This Guide highlighted SNPs’ potential to improve the quality of care for individuals with complex or chronic health care needs while containing costs. It also

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<sup>1</sup> The Guide is available on our website, [www.communitycatalyst.org](http://www.communitycatalyst.org).

focused on the need for CMS to set stronger standards around SNP benefit design and health delivery structures, establish stronger oversight mechanisms, and enhance enforcement capabilities.

We appreciate the steps CMS is taking in the proposed regulations to set stronger requirements for SNPs. In the absence of stronger federal standards, consumer advocates have raised questions as to whether SNPs are truly serving the needs of special needs beneficiaries in a cost-effective manner. The standards articulated in the proposed regulations, while long overdue, address some of these concerns, provide some much-needed structure to the program, and set additional protections for SNP beneficiaries. We do, however, have concerns that the proposed regulations do not go far enough to ensure that SNPs are distinguishable from mainstream Medicare Advantage plans. These concerns and our additional recommendations are articulated below.

### **Targeting SNP Enrollment to Special Needs Individuals** (§422.4)

We believe that *all* SNP beneficiaries should be required to be special needs individuals. SNPs were created to improve the quality of care for traditionally high-cost, high-use beneficiaries while simultaneously containing costs. Allowing non-special needs individuals to enroll in “disproportionate SNPs” dilutes the focus of these plans and frustrates their purpose. Instead of establishing a 10% enrollment cap for non-special needs enrollees, we recommend that CMS require that all new SNP enrollees qualify as special needs individuals. To avoid hardship, non-special needs individuals who are already enrolled in disproportionate SNPs might be grandfathered in and/or provided with assistance in finding a new, more appropriate health plan.

If, however, disproportionate SNPs are permitted to continue to operate, enrollment by non-special needs individuals into the SNP should be available only as an exception for the spouses and children of the SNP’s special needs beneficiaries. New non-special needs applicants that meet these requirements should be considered on a first-come, first-serve basis to avoid discrimination. In no event should the percentage of non-special needs individuals in a disproportionate SNP exceed the more restrictive 5% enrollment cap recommended by MedPAC.<sup>2</sup>

### **Verification of Eligibility** (§422.52)

We support requiring SNPs to verify whether an applicant qualifies for eligibility prior to enrollment. Under the proposed regulations, SNPs serving dually eligible beneficiaries would have to establish a process, approved by CMS, for obtaining information about an applicant’s Medicaid status prior to enrollment. This is a positive development, one that walks hand in hand with the proposed requirements for integration of benefits for SNPs serving dual eligibles. At the same time, it raises questions as to what degree consumer privacy interests might be compromised in the verification process. To appropriately safeguard consumer privacy while working towards integration, CMS should limit the scope

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<sup>2</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2008. Recommendation 3-5.

of information to be shared under this requirement to what is necessary to verify Medicaid eligibility for a current SNP enrollee or applicant—nothing more. Finally, CMS should impose sanctions for privacy violations or misuse of patient information.

### **Integration of Medicare/Medicaid Systems and Benefits** (§422.107)

We applaud CMS for requiring SNPs that serve dually eligible beneficiaries to establish formal relationships with the States in which they operate. We believe that integration, when properly organized, administered, and closely monitored, offers the opportunity to introduce a degree of fiscal stability and predictability to both Medicare and state Medicaid budgets while improving beneficiary access to quality care. Ideally, Medicaid and Medicare dollars should be *combined*, with a SNP organizing, arranging, and coordinating the delivery of all necessary resources and services to the beneficiary. This scenario would present special needs individuals with a full array of Medicaid and Medicare benefits and would give plans the flexibility they need to provide care that allows beneficiaries to remain living in their homes or communities.

At the same time, we share legitimate concerns with consumer advocates and policymakers that, absent stronger regulatory oversight and enforcement capabilities, the SNP program might (1) result in one-sided savings that bypass States altogether and/or (2) fail to include adequate standards, resulting in fewer protections for beneficiaries. In order to ensure that integration efforts are fully and properly supported, CMS must continue its work to create a regulatory environment that minimizes administrative burdens, includes meaningful consumer protections, and allows for complementary state and federal oversight of SNPs. We recommend that CMS create a permanent structure within the agency that promotes integration by engaging directly with plans and interested states as they enter the contracting process. CMS must also develop policies, procedures and models that allow for joint oversight and equitable distribution of cost savings. For example, this integration “office” could look to existing models where states have, as a contract requirement for plans with capitation rates, required plans to send back to the state a graduated percentage of their savings when the plans’ total medical expenses fall below a certain threshold.<sup>3</sup>

Because measures for care management and care transition are interdependent with integration measures, it is critical that CMS evaluate SNPs serving dually eligible individuals based on their effectiveness in coordinating Medicaid and Medicare benefits. Requiring SNPs to form relationships with states is a key component towards promoting effective integration. Of course, it may also prove to be a double-edged sword for the SNP program. On the one hand, it gives states additional leverage by allowing them an opportunity to set additional conditions for SNPs around shared savings, beneficiary protections, care coordination, and so forth. This is positive since, in the absence of strong standards and oversight, consumer experience in the current SNP marketplace has varied greatly, and not always for the better. On the other hand, some states are simply not interested in entering into formal arrangements with any SNP, making it impossible for even a quality, mission-driven SNP to expand its service area or enter the SNP market. Given these challenges, we recommend that CMS develop a process that permits these SNPs to describe their efforts to

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<sup>3</sup> See, e.g., MassHealth Senior Care Options Program Contract, Shared Savings, p. 90.

enter into relationships with states. Through this process, where a SNP can demonstrate both a good faith effort to reach an agreement and that State or other policies have prohibited it from doing so, CMS might except the plan (assuming it meets all other standards) from this requirement.

### **Model of Care** (§ 422.101(f))

We applaud CMS' efforts to direct plan sponsors toward a conceptual model of care for coordinating and delivering health care services to SNP beneficiaries. However, we believe that the proposed regulations do not go far enough. We would strongly urge CMS to add additional requirements and set firmer standards as to what SNPs must include in their models of care. While it is true that a variety of models for delivering coordinated care exist, we are concerned that CMS' posture of "deliberate silence" with regard to certain elements—namely, specific staff structure and network composition; case management for *all* enrollees as a matter of right; and communications systems among providers, enrollees and caretakers—will permit some SNPs to continue providing coordinated care "in name only."

### **Establish Mechanism to Coordinate Interdisciplinary Teams**

CMS should require SNPs to establish mechanisms to coordinate interdisciplinary teams of clinical staff and other providers who work together to ensure appropriate responses to members' health needs. Though these mechanisms may take a variety of forms, they should, at a minimum, (1) help the member navigate the health care delivery system (for dually eligible beneficiaries, this means both Medicare and Medicaid) and (2) allow for successful care transitions by preparing and coordinating care between enrollees, caregivers, and the clinical team.

CMS should also require SNPs to establish protocols whereby consumers entering or leaving a SNP during a course of treatment can continue treatment to completion with their existing providers, even if those providers are out of network. Similarly, SNPs should be required to work with consumers whose care is interrupted due to annual changes in their benefits packages or changes to the plan's network composition. As mentioned below, these changes should not occur without sufficient notice and explanation given to the enrollee. At a minimum, these protections should be in place for physical and behavioral health services and providers.

### **Require Case Management for All SNP Enrollees As a Matter of Right**

CMS should require SNPs to provide case management to all beneficiaries as part of the plans' models of care. While some enrollees may need more complex case management, *all* SNP enrollees should receive case management as a matter of right since SNP members are, by definition, people with chronic conditions and/or complex health needs. Case management should not, therefore, be limited to a particular subset of SNP enrollees.

Furthermore, CMS should set clear definitions as to what constitutes effective, quality case management. At a minimum, SNPs should be required to do the following:

- Conduct a **comprehensive health assessment** for each member at the time of enrollment that evaluates the enrollee’s medical, functional, psychosocial, environmental, and cultural and financial competencies and that makes provision for **at least annual reassessments**;
- Develop an **individualized, multidisciplinary case management plan** that includes a single “point” provider who is informed of, and involved in, all major decision-making as to the member’s care;
- **Review the member’s case management plan regularly** to assess progress toward goals and make modifications when necessary based on the member’s unique circumstances;
- Use high-risk screening **tools to identify members at risk of an adverse event** that could compromise the member’s health/wellbeing or increase health care costs and to prevent or lessen the impact accordingly;
- Establish a **process to identify risk factors and to plan interventions** in a manner that protects consumers’ rights and respects/includes the beneficiary;
- Establish mechanisms that ensure **beneficiaries and their families are involved** in care decisions;
- Establish systems for utilizing a **single medical record** with timely and effective communication among caregivers, providers, and members;
- Provide incentives and administrative **support for network providers** to optimize performance, prevent delays, and enable use of common medical records and team management;
- **Educate members about assistance** available for getting referrals, understanding plan policies and procedures, and coordinating care; and
- **Maintain regular, documented, and personal contact** with enrollees.

*Require SNPs to Establish Systems for Seamless Access to a Patient’s Health Information and Treatment Plan*

To be effective, a case management plan must be supported by health systems that are accessible to the entire care delivery team. Establishing 24/7 access to health information and care coordination services should be a core component of every SNP’s model of care in order to ensure continuity of care across all clinical settings. SNPs should be required to develop mechanisms for creating and sharing a centralized medical record—preferably an electronic medical record—that is available to all providers and on-call staff. Creating this kind of access allows the provider team to accurately document the member’s medications, treatments, and other services and will reduce questions about care, flag potential problems, and eliminate duplicative treatments.

*Set Standards for Determining Whether a SNP Provider Network Adequately Meets the Needs of Its Members*

In addition to requiring SNPs to have provider networks with expertise appropriate to the needs of their enrollee population, CMS should require SNPs to include providers with disability and language competencies tailored to their populations and geographic areas. Furthermore, many of the most vulnerable members of the SNP population require a broader array of benefits than those covered under MA law, which is limited primarily to acute and primary care. In order to successfully meet the needs of its frail, disabled, or chronically ill

members, a SNP's provider network must also demonstrate a unified, multidimensional approach to care that anticipates and coordinates members' long-term care needs. SNPs that serve dually eligible beneficiaries should also be required to either include only providers who participate in Medicaid or, where appropriate, make provision for coverage of providers/services not in Medicaid. Finally, SNPs should be required to select providers who agree with the policies and practices behind its model of care.

#### Maintain Meaningful Consumer Involvement

SNPs should also be required to develop formal processes for proactively gathering consumer guidance and engagement about how to improve plan design, provider networks, member information, and implementation. While there is no single best mechanism for allowing members' voices to be heard, SNPs might consider a variety of strategies, including the following:

- Routinely measuring different aspects of member/family/immediate caregiver satisfaction;
- Working with leaders from the consumer and disability communities;
- Holding public meetings and focus groups with members; and
- Forming advisory and oversight committees with consumers and their advocates.

#### **Balance Billing Dually Eligible Beneficiaries** (§422.504(g)(1))

We strongly support requiring all MA organizations with dually eligible enrollees to specify, in their provider contracts, that enrollees will not be liable for cost-sharing when Medicaid is liable. SNPs should also be held responsible for informing *enrollees* about their rights and responsibilities under Medicare and Medicaid. We support clear, unequivocal requirements that SNPs serving dually eligible individuals (a) educate their enrollees about the benefits and rules of each program, and (b) pursue payment from the State, when necessary, for Medicaid covered services. In addition, we think that SNPs should be required to help enrollees with the appeals process for adverse coverage decisions.

#### **Marketing**

Overall, CMS' proposed limitations on marketing activities are a positive step towards affording SNP enrollees adequate protections from marketing abuses. SNP-eligible beneficiaries are prime targets for these abuses. Because their generally poorer health means they bring higher rates with them under the risk-adjustment system, they are more at risk of being victims of improper marketing tactics. Dually eligible beneficiaries, in particular, tend to have a lower literacy rate than other beneficiaries, making appropriate guidelines for marketing materials even more crucial. And, because dually eligible individuals may enroll in a SNP at any time, they are particularly vulnerable to these abuses.

#### Plan Information (§§ 422.111 and 423.128)

Because the hallmark of a SNP should be the implementation of a case management plan for all members, CMS should require SNPs to provide members at the time of enrollment with a clearly written explanation about how the case management process works. Further, since

SNP enrollees may not understand how managed care and provider networks operate, CMS should require SNPs serving dually eligible beneficiaries to develop the following materials as part and parcel of their marketing materials and beneficiary education packets:

- A comparison of their benefits, other features, and performance to other Medicare Advantage plans and fee-for-service Medicare;
- Accurate information, as confirmed and approved by the State’s Medicaid agency, describing Medicaid’s coverage of services not covered by SNP and coverage of cost-sharing obligations within SNP;
- A basic outline of how the SNP’s managed care coverage works, how to obtain information and access the provider networks, and how to get help and referrals from the SNP; and
- An explanation of coordination of care benefits.<sup>4</sup>

Prohibited Marketing Activities (§§422.2272 and 423.2272)

We commend CMS for establishing explicit prohibitions against activities such as door-to-door solicitation, cold calling, and other unsolicited forms of direct contact. We recommend adding an explicit prohibition against cold calling and/or sales activities in senior housing developments.

We believe that the prohibition against conducting sales activities in locations where patients intend to receive health care services is necessary and proper to avoid opportunities for coercion in the current SNP marketplace. However, this broad prohibition will also inhibit conversations between providers who participate in SNPs that operate as clinical organizations and special needs patients who would benefit from enrolling in a SNP. At Commonwealth Care Alliance in Massachusetts, for example, participating primary care providers receive capitated payments for coordinating care for SNP beneficiaries (i.e., they lack financial incentive for enrolling beneficiaries into the plan). The proposed prohibition would prevent these providers from recommending this SNP to their patients, even though enrollment would mean the patient received better coordinated, quality care. We therefore encourage CMS to continue to further define the process by which providers, in the absence of financial incentives, might appropriately recommend a SNP to their special needs patients. For example, CMS might consider creating an exception to this prohibition for SNPs that operate as *prepaid* clinically-based programs.

New Requirements for Independent Agents (§§422.2272 and 423.2272)

We appreciate the steps CMS has taken to set firmer standards and provide greater protections against marketing abuses, particularly with regard to the removal of financial incentives through the establishment of a flat fee commission structure. Despite this, we remain very concerned that the current compliance and enforcement mechanisms laid out in the proposed regulations will not be enough to deter these abuses or to hold SNPs properly accountable for abuses by independent contractors. We recommend that CMS implement the model used by states in regulating Medicaid managed care marketing by prohibiting MA plans from using independent agents for marketing purposes altogether.

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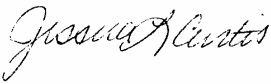
<sup>4</sup> See Halperin, Alissa Eden, Esq., “Medicare Advantage Special Needs Plan Experience: Beneficiary Perspective from Pennsylvania.”

**Conclusion**

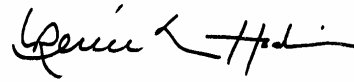
The standards established for SNPs in the proposed regulations, while a positive step forward, do not go far enough to ensure that SNPs meet the needs of the populations they were intended to serve. In particular, we urge CMS to hold SNPs to a higher standard by establishing stronger requirements around integration, models of care, and marketing that ensure SNP beneficiaries are getting the quality of care they need and the program achieves anticipated cost savings.

We welcome the opportunity to work with your office further as you continue this important work.

Sincerely,



Jessica L. Curtis  
Staff Attorney



Renée Markus Hodin  
Project Director