NYLAG
New York Legal Assistance Group

Dec. 24, 2020

VIA ELECTRONIC SUBMISSION

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

RE: New York Section 1115 Medicaid Redesign Team Amendment Request - MLTC Eligibility Restriction & Default Enrollment for Certain Dual Eligibles (11-W-00114/2)

Dear Sir/Madam:

The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services and financial counseling, and engages in policy advocacy efforts, including health access advocacy, to help people experiencing poverty. NYLAG submits these comments opposing New York's request to amend the 1115 Waiver to limit eligibility to enroll in Managed Long Term Care (MLTC) plans to those needing assistance with a minimum number of Activities of Daily Living (ADL), as these restrictions discriminate based on diagnosis and fail to count key ADLs like transfer, medication administration and incontinence care. The proposal to keep new Medicare beneficiaries in their former Medicaid managed care plans by default enrollment, if they are enrolled in a Dual-Special Needs Plan [D-SNP] operated by the same insurance company, has serious gaps to ensure that enrollment is voluntary and procedures must be developed and tested.

1. **CMS should consider the recent GAO report, which points out serious problems in New York's MLTC program,[1] and other issues raised by recent litigation concerning member rights and oversight.** We endorse and incorporate by reference the comments submitted by the National Health Law Program on this point.

2. **The Minimum Two or Three ADL Limit Unlawfully Denies MLTC Enrollment and Services Based on Diagnosis, Violating Medicaid Regulations and the Community First Choice Option (CFCO) That Require States to Provide Cueing and Supervision as well as Hands-On Assistance**

3. **Voluntary Mainstream Enrollment for Certain "Well" Dual Eligibles Should Not be Approved Without Addressing Serious Procedural Gaps**

[1] U.S. Government Accountability Office, *Medicaid Long-Term Services and Supports (MLTSS): Access and Quality Problems in Managed Care Demand Improved Oversight*, Report to the Chairman, Committee on Energy and Commerce, House of Representatives (Nov. 2020), https://www.gao.gov/assets/720/710680.pdf.

2. The Minimum Two or Three ADL Limit Unlawfully Denies MLTC Enrollment and Services Based on Diagnosis, Violating Medicaid Regulations and the Community First Choice Option (CFCO) That Require States to Provide Cueing and Supervision as well as Hands-On Assistance

This waiver amendment should be denied because it will deny enrollment to certain consumers based on their diagnosis. The proposed restriction would implement a recent amendment to the state Medicaid law that set a minimum number of two or three ADL's to qualify for eligibility for both: (1) MLTC enrollment and (2) Personal Care Services (PCS) and Consumer Directed Personal Assistance Program (CDPAP) services in the State Medicaid Plan, whether provided Fee for Service or through an MLTC or "mainstream" Medicaid Managed Care plan ["MMMC"].[2] On September 29, 2020, New York submitted a State Plan Amendment to CMS to approve this restriction as applied to eligibility for State Plan PCS and CDPAP services. This request is still pending.[3] The waiver amendment proposed here would deny enrollment to would-be MLTC members based on their diagnoses – the same basis for restricting eligibility for State Plan PCS and CDPAP services. If the State Plan Amendment is approved, the new criteria will be used to deny PCS and CDPAP services altogether to certain New York Medicaid recipients, whether through Fee for Service or through MLTC or MMMC plans, based on their diagnosis, in violation of federal Medicaid regulations including requirements for the Community First Choice Option (CFCO) that New York is scheduled to implement in MMMC and MLTC plans.

If CMS permits New York to restrict eligibility to those who need assistance with a minimum number of ADLs, then eligibility based on the need for supervisory assistance with two ADL's must be expanded to any person who needs such assistance because of *any* diagnosed impairment, not limiting eligibility to those with a dementia or Alzheimer's diagnosis. Additionally, instead of considering only the need for ADLs, the need for assistance with Instrumental ADLs (IADLs) must be considered as well to qualify for enrollment, since these are essential for independent living.

A. The Definition of Who Must Have Two or Three ADLs to Qualify for Services Must be Amended to Prevent Denial of Eligibility based on Diagnosis and to Comply with CFCO Requirements.

i. MLTC Enrollment Will Be Denied to Those who Need Supervisory Assistance with Two ADLs Based on Having a Diagnosis Other Than Dementia or Alzheimer's Disease

The waiver amendment would deny MLTC enrollment for those who, because of an impairment other than dementia or Alzheimer's, need supervisory assistance with more

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[2] The 2020 amendment of the eligibility criteria for PCS and CDPAP State Plan services is set forth at Social Services Law § 365-a, subd. 2 (e)(v); the same ADL restrictions on eligibility to enroll in MLTC plans is set forth at NY Public Health Law § 4403-f subd. 7(b)(v)(14).

[3] New York's proposed State Plan amendment is posted at https://www.health.ny.gov/regulations/state_plans/status/ltcare/original/docs/os_2020-09-29_spa_20-41.pdf. By letter of Oct. 29, 2020, NYLAG submitted comments to the State on the proposed SPA (copy available at http://www.wnylc.com/health/download/759/). These comments point out, among other things, that the State failed to give timely public notice of this proposed SPA for public comment.

than one ADL but do not need "limited assistance with physical maneuvering" with more than 2 ADLs. People with vision impairments, traumatic brain injury (TBI), developmental disability (DD), and other cognitive, neurological or psychiatric impairments may need supervision with 2 or more ADLs but not physical maneuvering with 3 or more ADLs. They would be denied MLTC enrollment and PCS/CDPAP services solely based on their diagnosis, since those with dementia with the identical functional needs would be eligible. "The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." 42 C.F.R. §440.230(c).

In the Public and Tribal Notice discussion in the waiver amendment request, New York acknowledged receiving comments stating that the new eligibility criteria would deny access to services solely based on diagnosis. The State's response to these comments is totally inadequate, stating in part:

> "… affected individuals will remain entitled for all fee-for-service and MMMC services for which they qualify, which are either already in place to address their needs or may be subject to future care linkages coordinated by the individuals' local departments of social services or MMMC plans…'

This response is misleading because it suggests those denied MLTC enrollment under the new criteria will remain entitled to fee-for-service or MMMC PCS or CDPAP services. In fact, they will be denied PCS or CDPAP services on a Fee for Service basis or through MMMC because the same new restrictive criteria will apply. It is true that the State will grandfather in under the old criteria those already enrolled in MLTC plans or already receiving PCS or CDPAP through fee for service or MMMC plans, but this does not solve the problem of discriminating against NEW APPLICANTS for these services based on diagnosis.

ii. *The Two and Three-ADL Limits Violate CFCO Regulations*

The denial of PCS/CDPAP for those who otherwise meet the level of care requirements for CFCO services also violates the CFCO regulations, which prohibit discrimination based on diagnosis. New York has delayed inclusion of CFCO in MLTC, but since this is imminent, the policies should comply now. "States must provide Community First Choice to individuals …[i]n a manner that provides such services and supports … *without regard to the individual's age, type or nature of disability*, severity of disability, or the form of home and community-based attendant services and supports that the individual requires to lead an independent life." 42 C.F.R. § 441.515 (emph. added).

Also, the requirement that an individual who does not have dementia or Alzheimer's disease must need "physical maneuvering" with at least three ADLs potentially violates CFCO requirements that states provide ADL and Instrumental ADL ["IADL"] assistance not only through hands-on assistance but also through supervision and cueing. A PCS or CDPAP applicant is eligible for CFCO if, without home care services, they would require an institutional "level of care" – whether in a nursing home, psychiatric hospital, or Intermediate Care Facility for Developmental Disabilities (ICF-DD). An individual with a TBI, or a developmental, neurological, psychiatric, or other cognitive impairment, may well, in the absence of PCS or CDPAP services, require an institutional level of care in one of these types of facilities. If an individual meets the CFCO level of care criteria,

"…the State must provide …[a]ssistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing." 42 C.F.R. § 441.520(a). In the CFCO Technical Guide, CMS clarified, "CMS reminds states that all three ways of delivering assistance with ADLs, IADLs and health related tasks must be made available. States may not limit the scope of this benefit to offer less than all three." [4] The proposed amendment would deny MLTC enrollment – and eligibility for PCS or CDPAP altogether -- to an individual who needs supervision and cueing with one ADL and three IADLs, even though meeting the level of care criteria for CFCO.

iii. RECOMMENDATION

Instead of requiring specific diagnoses to qualify for MLTC enrollment based on needing supervision with two or more ADLs, any person who, because of any diagnosed impairment(s), needs supervision with more than one ADLs should qualify.

Additionally, instead of requiring two or three ADLs, Instrumental ADLs (IADLs) must be considered as well. The consumer's inability to prepare meals, do laundry, grocery shop, and perform other household tasks can make them unable to live safely in their homes, increasing the risk for falls and other accidents which can lead to unnecessary hospitalization and institutionalization.

B. The Definition of ADL Must Include Transfer for purposes other than Toileting and Medication Administration

The waiver amendment request does not define which ADL's would count toward the minimum of two or three required for MLTC enrollment, but New York State recently published proposed regulations that omit three key ADLs – transfer, all assistance with elimination, and medication administration. [5]

The proposed regulation includes "transfer" only as part of the ADL of toilet use, listing as one ADL: "transferring on to and off the toilet and toilet use." Proposed 505.14(a)(9) and 505.28(b)(1). Transfer is an ADL apart from assistance with toileting, including transfer from or to bed or chair. Some consumers who require assistance with transfer to and from bed or chair may use a catheter, so do not need assistance in transferring to a toilet. If transfer is not listed separately as an ADL, they would be improperly denied MLTC enrollment. Likewise, MLTC enrollment would be denied to an individual who may be able to walk independently with a walker but not be able to stand up (transfer) without assistance. Listing "transfer" as a separate ADL would ensure their needs are considered in eligibility for MLTC enrollment.

Also, other than transfer on and off the toilet, the ADL of toileting is described solely as "toilet use." This should be expanded to include all assistance with elimination including incontinence care. Finally, medication administration is an essential ADL, for which some individuals need cueing and supervision to take medication from a pre-poured medication box. Others need an aide to bring them the pre-poured medication and a glass of water.

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[4] CMS, Community First Choice State Plan Option Technical Guide, available at https://www.medicaid.gov/sites/default/files/2019-12/cfc-technical-guide_0.pdf.

[5] Notice of proposed regulation in NY State Register, Vol. XLII, Issue 28, p. 16 (July 15, 2020) content available at https://regs.health.ny.gov/regulations/proposed-rule-making.

C. To Protect Current Enrollees, the Definition of Who is "Grandfathered" under the Former Eligibility Requirements Must be Modified

The waiver amendment states, "To avoid any impact on recipients currently enrolled in MLTC plans, individuals enrolled in MLTC plans continuously as of December 31, 2020 will remain eligible and be reassessed using the former criteria applicable prior to January 1, 2021."[6] However, people in fee for service are grandfathered in to the old criteria if they merely *applied* for CDPAP services before the operative date,[7] or received an initial authorization for PCS before the operative date."[8] They do not have to meet they higher burden of having been continuously enrolled in an MLTC plan to be grandfathered in.

The definition of who is grandfathered in under the old criteria must be tweaked to ensure that managed care plans make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a) (4)(i). In order for MLTC services to be made available to the same extent they are available through fee for service, anyone who initially sought eligibility for (applied for) PCS, CDPAP or MLTC before Dec. 31, 2020 (or such later date as these amendments become effective) must be grandfathered in.

If only individuals who have been continuously enrolled in the MLTC program prior to Dec. 31, 2020 are grandfathered in to the old criteria, this potentially denies grandfathered status – and MLTC eligibility -- to at least three groups of consumers who would be grandfathered if they were fee for service.

1. *Individuals who enroll in MLTC on January 1, 2021, being required to transition from fee for service PCS or CDPAP or from an MMMC plan when they become enrolled in Medicare*. Many consumers initially begin receiving PCS or CDPAP on a fee for service bases under the "immediate need" program, and then after 120 days must transition to an MLTC plan. The same is true for MMMC enrollees who become enrolled in Medicare. These consumers could be denied MLTC enrollment under the new ADL requirements even though they are grandfathered in under the PCS and

[6] This grandfather clause is based on the 2020 amendment of the state law governing MLTC, which states that the new ADL criteria "…shall not apply to a person who has been continuously enrolled in a MLTC program beginning prior to October 1, 2020." NY Public Health Law §4403-f subd. 7 (b)(v)(14), added by L. 2020, Ch. 56 §18. The waiver amendment thus moves the effective date back three months from Oct. 1, 2020 to Jan. 1, 2021.

[7] The grandfather clause for CDPAP states, "…the provisions related to activities of daily living in this paragraph shall only apply to persons who initially seek eligibility for the program on or after October 1, 2020."Soc. Serv. Law §365-f, subd. 2(c)(eff. Oct. 1, 2020), as amended, L. 2020, Ch. 56 §3. The State did not implement these changes in Fee for Service on Oct. 1st, and they can be presumed to be postponed until Jan. 1, 2021, just like the MLTC eligibility changes.

[8] For personal care, the law states, "The provisions of this subparagraph shall only apply to individuals who receive an initial authorization for such services on or after October 1, 2020. Soc. Serv. Law §365-a, subd. 2(e)(v)(eff. Oct. 1, 2020), as amended, L. 2020, Ch. 56 §2-a. This date has presumably been moved back to Jan. 1, 2021 as for MLTC.

CDPAP amendments because they either initially applied for CDPAP before Dec. 31, 2020 or were initially authorized for PCS before that date. See n 7-8.

2. *Individuals enrolled in MLTC before Dec. 31, 2020, but whose enrollment was disrupted because of a problem during the Medicaid renewal process.* Mailing delays or processing errors in the annual Medicaid renewal process often cause discontinuance of Medicaid, and then cascade into disenrollment from the MLTC plan, requiring the consumer to re-enroll. Under the proposed waiver language, such consumers would not be "continuously enrolled" in the MLTC so would be subject to the more restrictive eligibility criteria, even though they would have been grandfathered in for PCS/CDPAP services had they received them fee for service.

3. *MLTC members who are disenrolled from the plan after being in a nursing home for three months ("Long Term Nursing Home Stay" or LTNHS*). Under an 1115 amendment approved by CMS Dec. 19, 2019, LTNHS individuals are disenrolled from MLTC plans. Since New York began implementing this change in August 2020, at least 20,000 MLTC members have been disenrolled. Potential barriers to re-enrollment exacerbated by the more restrictive ADL criteria post serious *Olmstead* concerns for those trying to leave nursing homes. Though the State has said that institutionalized enrollees actively engaged in a discharge plan would not be disenrolled, NYLAG and other organizations have represented numerous consumers who were wrongly disenrolled, *some even after they returned home from the nursing home* with MLTC PCS or CDPAP services reinstated! Even MLTC members mistakenly disenrolled might not be grandfathered into the former criteria when they try to re-enroll, because they were not "continuously enrolled" prior to Dec. 31, 2020. Yet they remain eligible for PCS/CDPAP because they initially applied for or were authorized for PCS or CDPAP services prior to Oct. 1, 2020 (or Dec. 31, 2020 if that date is moved back).

   Also, in its Dec. 19, 2019 letter approving the LTNHS waiver amendment, CMS stated that consumers who were disenrolled based on LTNHS could re-enroll within six months without a conflict-free evaluation.[9] However, this new waiver amendment throws that into question, since they could be subject to the new more restrictive enrollment criteria because they were not continuously enrolled in the MLTC plan. Others disenrolled because of LTNHS may miss the six-month deadline to re-enroll in an MLTC plan, given how common enrollment delays are.

[9] The Dec. 19, 2020 letter had been posted at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-medicaid-rdsgn-team-ca.pdf. However, the letter at that link has been replaced by a subsequent CMS letter regarding the same 1115 waiver dated April 16, 2020.

3. Voluntary Mainstream Enrollment for Certain "Well" Dual Eligibles Should Not be Approved Without Addressing Serious Procedural Gaps

This proposed waiver amendment would keep MMMC plan members who become eligible for Medicare, and who do not need community-based long term care ["CBLTC"] services, in their MMMC plans through default enrollment, if they are enrolled in a Dual-SNP operated by the same insurance company. This would be a change from current law, in which these so-called "well duals" are disenrolled from the MMMC plan when they become eligible for Medicare, and have Fee for Service Medicaid as secondary coverage to Medicare, unless they elect to enroll in a fully integrated plan – Medicaid Advantage -- which combines Medicare and Medicaid in one plan. We recognize that the 2018 Balance Budget Act requires that beginning in 2021, D-SNPs must meet new requirements for integration and that the Medicare regulations were amended in 2018 to allow Default Enrollment of some dual eligibles into D-SNPs, with certain protections. However, though operated by the same insurance company, the Medicare D-SNP and the MMMC plan are separate plans, not one integrated plan, which does not accomplish the goal of expanding options for integrated care.

NYLAG counsels and assists many dually eligible New Yorkers as they become eligible for Medicare and this proposal presents several questions and concerns. This waiver amendment should not be approved without extensive protections that ensure access to coverage and integration of systems between the D-SNP and the MMMC plan. Also, dually eligible New Yorkers must be presented with all options for receiving their Medicare and Medicaid. Consumer choice is critical. The waiver pays lip service to these goals but does not provide enough assurances of accomplishing them, including testing of systems to ensure continuity of care and prevent disruption of services.

A. If this is VOLUNTARY Enrollment in the MMMC plan, an "exemption" from mandatory MMC enrollment should not be required.

The proposed waiver amendment emphasizes that a "well dual" who is voluntarily enrolled in the Medicare D-SNP may voluntarily remain in the MMMC plan in which they were enrolled before they became enrolled in Medicare. Waiver amendment at p. 5. The requested amendments of the tables in the Special Terms & Conditions of who is excluded or exempt from mandatory enrollment in MMMC plans are not consistent with the request.

The proposed amendment to Table 2, which lists individuals excluded from MMMC enrollment, needs the following suggested change in order to ensure that MMMC enrollment is limited to "well duals," and excludes those who need CBLTC services:

> **Table 2: Individuals Excluded from MMMC (including HARP and HIV SNP)**
>
> Medicare recipients who are not enrolled in a Medicare D-SNP with a qualified MMMC plan, and
>
> Medicare recipients who are enrolled in a Medicare D-SNP but do not need Community-Based Long Term Care Services (CBLTCS) for a continuous period of more than 120 days

The proposed amendment to Table 3 of individuals exempt from MMMC should be rejected altogether. As proposed it would exempt "Medicare recipients who are enrolled in a Medicare D-SNP with a qualified MMMC plan." Recipients who are exempt from enrolling in MMMC are subject to mandatory enrollment unless they request or assert an exemption. If enrollment of "well duals" is voluntary, then they are simply not subject to mandatory enrollment. They should not have to assert or request an exemption from enrollment. It is sufficient that Table 2 is revised so that they are not excluded from enrollment. However, if CMS approves default enrollment of this group with the right to opt-out, then this exemption should remain on the list.

B. Relationship with Default Enrollment into Medicare D-SNPS – Protections Needed to Ensure Voluntary Enrollment in both the D-SNP and the MMMC plan

The proposed waiver amendment is silent on whether the new voluntary enrollment of "well duals" in their current MMMC plans would coincide with the implementation of default enrollment of dual eligibles into Medicare D-SNPs, pursuant to 42 C.F.R. 622(c)(2), as amended in 2018, or whether the proposed MMMC enrollment is on a faster track. Either way, protections are needed to ensure that enrollment in both plans – the Medicare D-SNP and the MMMC plan -- is voluntary. The waiver amendment implies that the so-called "voluntary" enrollment is through default enrollment of those who are enrolled in a Medicare D-SNP into the same sponsor's MMMC plan with the right to "opt out." (see p. 13). NYLAG strongly opposes default enrollment with the right to opt out. Instead, enrollment should be a voluntary, affirmative decision to remain in their MMMC plan by *opt-in*. From our experience working with consumers subject to default enrollment, many often are unaware of their so-called "voluntary enrollment" until after the enrollment has occurred, when they learn that a preferred provider is not in-network. We strongly prefer "opt-in" enrollment, where the default is fee for service Medicaid, to ensure that enrollment is truly voluntary.

If this amendment is to be implemented before default enrollment is implemented for Dual-SNPs, then assurances must be included to ensure that enrollment in the Dual-SNP is truly voluntary. This requires strict marketing restrictions by which the MMMC plan informs the member of the option to enroll in the Medicare D-SNP product – and of the option to remain in the MMMC plan. This marketing must be closely monitored.

If new dual eligibles who are voluntarily enrolled in the affiliated Medicare D-SNP plan would remain in their MMMC plan through default enrollment, then adequate protections must be provided to ensure that MMMC members receive as much notice as possible of their right to opt out of enrollment. Such protections should include:

- at least two notices clearly explaining the automatic enrollment process with simple step-by-step instructions and non-biased resources for the member to call, such as the statewide consortium, Community Health Advocates -- <https://communityhealthadvocates.org/who-we-are/>--

- the option to disenroll for at least three months post-enrollment; and
- at least 90 days of continuity of care rights when a current D-SNP provider relationship does not contract with the MMMC.

We are pleased to read that "…the Department is considering focus group reviews of materials and member notices to obtain additional feedback from dual eligibles and/or caregivers." Such focus groups should be required in the waiver, with proposed materials and draft notices, along with feedback from the focus groups, posted for public comment.

C. Challenges of Timing the Re-determination of Medicaid Eligibility – switching from MAGI to Non-MAGI for Those New to Medicare -- with the Proposed MMMC Enrollment Process

Most, but not all, Medicaid recipients who are enrolled in MMMC plans and who become enrolled in Medicare had MAGI Medicaid, and now must have their Medicaid eligibility redetermined under the more restrictive non-MAGI rules. NYLAG informally calls the eligibility redetermination under non-MAGI rules "falling off the cliff" because many people lose Medicaid eligibility in this transition; either they do not pass the non-MAGI resource test, as MAGI Medicaid has no resource test, or their income exceeds the lower income limits for non-MAGI Medicaid in New York.[10]

In its waiver amendment request, New York acknowledged receiving comments pointing out the problems with timing these redeterminations with the default enrollment process, and said it was working with the Medicare Medicaid Coordination Office (MMCO) on these issues. However, the waiver amendment should not be approved until these procedures are both established and tested. Both the initial Default Enrollment into a Medicare Dual-SNP, which is nearing implementation in New York, and the default enrollment into a qualified MMMC plan, presume that the individual is eligible for non-MAGI Medicaid (or is a rare Medicare beneficiary who may keep MAGI budgeting as a caretaker relative). The redetermination process in New York takes at least four months, involving transfer of administration of Medicaid eligibility from the NYS of Health marketplace to the local social services district upon enrollment into Medicare.[11] The local district redetermines eligibility under non-MAGI rules, with Medicaid eligibility continuing until the local district either re-authorizes Medicaid or sends notice discontinuing Medicaid because of excess resources or excess income (or imposing a "spend-down"). The proposal puts the cart before the horse – the Medicaid

[10] Unlike some states, New York's non-MAGI income levels are much lower than MAGI. In 2020 the income limit for a single is $895, after the $20/mo. standard disregard, compared to the MAGI limit of $1468/mo. See NYS DOH GIS 19-MA-012, *2020 Medicaid Levels and Other Updates*, https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/19ma12.pdf

[11] See NYS DOH GIS 16 MA/004 -Referrals from NY State of Health to Local Departments of Social Services for Individuals who Turn Age 65 and Instructions for Referrals for Essential Plan Consumers; GIS 15 MA/022 - Continuous Coverage for MAGI Individuals; 2014 LCM-02 - Medicaid Recipients Transferred at Renewal from New York State of Health to Local Departments of Social Services (all directives available at https://www.health.ny.gov/health_care/medicaid/publications/index.htm)

redetermination must be completed *before* enrolling the individual into the Dual-SNP, since eligibility for the Dual-SNP hinges on having Medicaid.

Making timing even more difficult, the D-SNP must send notice of the right to opt out 60 days *prior to* the effective date of Medicare eligibility. The proposal gives no explanation for how this will work, other than saying these issues are being discussed with MMCO. This is not enough. For example, Medicare eligibility for an MMMC enrollee is effective October 1, the Medicaid redetermination would need to be completed by July so that the D-SNP could send the opt-out notice by August 1. The procedures currently used in New York State would not meet these deadlines to send notices to members in time to opt out. The waiver should not be approved until these procedures are all developed and tested.

If the enrollee is determined eligible for non-MAGI Medicaid, but with an income spend-down, she is excluded from enrolling in/remaining in the MMMC plan. See Table 2 of the Special Terms and Conditions, which lists the first exclusion from MMMC enrollment for "Individuals who become eligible for Medicaid only after spending down a portion of their income." This is an example of why the Medicaid redetermination must be completed well in advance of the default enrollment. This would require New York to completely revamp its redetermination process set forth in note 16.

D. Who Determines Who is and is not a "Well Dual" who May Enroll in the MMMC Plan (or who must Opt Out during Default Enrollment?)

The proposed waiver amendment differentiates those members of the MMMC plans who become enrolled in Medicare who are "found" not to need CBLTC. The proposal does not specify who makes this determination. Now, the MMMC plans are provided a list of their members who are expected to become enrolled in Medicare soon, and are asked to identify those members to whom the plan is providing CBLTC.[12] Those members are then passively enrolled into an MLTC plan once they are enrolled in Medicare. Presumably the same procedure would be used to identify those who are not receiving CBLTC from the MMMC plan, who would be subject to the new voluntary or passive enrollment into the qualified MMMC plan. However, just because the enrollee is not then currently *receiving* CBLTC from the MMMC plan does not mean she does not *need* CBLTC services. Since MMMC plans are not MLTC plans, they are not mandated to reach out to every member and assess them as to their need for CBLTC. Only those who affirmatively request CBLTC services from their MMMC plan are assessed for them and provided them. For these reasons, a system for identifying those members in need of CBLTC is needed, whether members are contacted and asked to self-identify as in need of CBLTC, or whether all members are assessed.

[12] See NYS Dept. of Health MLTC Policy 15.02: *Transition of Medicaid Managed Care to MLTC*, available at https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-02.htm.

E. What is the "Qualified MMMC plan" and How is it Integrated with the Medicare Dual-SNP?

The stated purpose of the proposed waiver amendment is to better integrate care for dual eligibles. The proposal does not describe, however, how the two plans will actually integrate care. Just because the two separate plans – the MMMC plan and the Dual-SNP -- are owned and operated by one insurance company does not automatically mean that the plans are integrated.

In the section on Budget Neutrality, the waiver proposal states, "The MMMC plan benefit package will similarly not change. Therefore, no changes to budget neutrality per member, per month (PMPM) costs are projected." Contrary to this representation, the MMMC benefit package of a "qualified" plan providing secondary coverage to a Dual-SNP is far more limited than the comprehensive coverage provided by MMMC plans for non-duals. Traditional MMC plans are the enrollee's sole insurer, since anyone with Third Party Health insurance is excluded from traditional MMC enrollment. In addition to the fact that the Dual-SNP provides the brunt of primary, acute and rehabilitative care, the qualified MMMC package even of Medicaid-only services is further limited since only "well duals" – those who do not need costly Medicaid CB-LTC services – may enroll. Traditional MMMC plans for non-dual eligibles *do* cover CB-LTC in their benefit package, but qualified MMMC plans will not. Also, the MMMC plan is not even paying cost-sharing for Medicare services, since Dual-SNP's have no cost-sharing. If the PMPM costs are not lower in these qualified plans for well duals, from the taxpayer's point of view, we question how the proposal will be budget-neutral and cost-effective.

Additionally, it is unclear whether a "qualified MMMC plan" combined with a D-SNP is the same or different than the current Medicaid Advantage plan option available to dually eligible individuals. If it is different, it presumably has even less care coordination and integration than Medicaid Advantage, which already has less than complete coordination and integration. This is a huge concern.

Among many issues involved in how the D-SNP and Qualified MMMC plan coordinate care are the following:

1. **The provider networks should be the same** in order to prevent any issues with the MMMC paying secondary to the D-SNP. We acknowledge that this might be the primary benefit of this model. The individual who may have developed relationships with providers in the MMMC plan may want to maintain those relationships. Requirements must be in place to ensure that the provider networks in both plans are the same, at least with respect to those services covered by both Medicare and Medicaid.
    a. **To the extent the networks may not entirely overlap, the MMMC plan must be required to pay copayments or coinsurance** for any service provided by a network Medicare D-SNP provider.
2. **There must be minimum requirements for integration and coordination** in order to prevent the two plans from operating in isolation of the other.

3. **The MMMC plan in which the member was enrolled should provide the Medicare Dual-SNP with the current care plan,** including all providers used and tests performed in the past year.
4. **Prior approval** requirements and procedures must be coordinated, and approval authorized by the Dual-SNP must be binding on the MMMC plan.
5. **For services covered by both Medicare and Medicaid**, the two plans must coordinate, with procedures in place to ensure that the Dual-SNP is billed first. For example, **physical, occupational and speech therapy, and home health care services** are covered by both Medicare and Medicaid, though to some extent in different amount, duration, and scope and with different criteria. It must not be left up to the consumer to figure out which insurance is covering the service. Network providers must be informed of how to bill both plans appropriately.
6. The MMMC benefit package will soon carve out **prescription drugs**, a change enacted in state law this year. Will a dual eligible enrolled in a D-SNP and the qualified MMMC receive additional comprehensive drug coverage fee for service?
7. Each member should have access to a **care coordinator** that can assist with navigating their Medicare and Medicaid benefits. Regular MMMC plans for non-duals are not required to assign care coordinators to all members.
8. An MMMC enrollee who, despite being enrolled in a D-SNP, chooses not to voluntarily enroll in/ remain enrolled in the qualified MMMC, still has the right to a certain amount of integration. In 2021, under the BBA there are new integration requirements and while the dual eligible may choose not to enroll in the D-SNP's qualified MMMC, the D-SNP must still provide greater integration in compliance with the BBA requirements. Since that is required, it should be made clear how the integration will be different for those who do enroll in both the D-SNP and qualified MMMC product, and those who do not.

F. Public Transparency on Selection of Medicare D-SNPS that will have a Qualified MMMC plan and Stakeholder Engagement

A list of which D-SNPs have a "qualified MMMC plan" should be publicly available, and should be included in the forthcoming NYS Department of Health webpage that we understand will be created for dually eligible New Yorkers.

It should be disclosed whether any of the Medicare D-SNPs that have a qualified MMMC will be HIDE or FIDE SNPs.

G. MMMC lock-in should not apply to these individuals.

Medicare rules provide for various enrollment periods including access to special enrollments periods. Therefore, since the lock-in does not and cannot apply to a Medicare plan we ask that the waiver confirm that the lock-in will not apply to dual eligibles enrolled in a D-SNP and its qualified MMMC.

H. There should be an educational outreach campaign for "well duals" impacted by this proposed waiver amendment.

Education and outreach for MMMC members must be timely and comprehensively presented. All stakeholders – consumers, their advocates as well as plans and providers -- should be engaged in the development of this educational effort and in drafting the enrollment notices. We have concern for individuals subject to default enrollment, once implemented, for the Medicare Dual-SNPs, who soon thereafter may then face the impact of this second round of default enrollment as proposed in this waiver amendment. Therefore, we request that this process be clearly outlined with special considerations for those just default enrolled.

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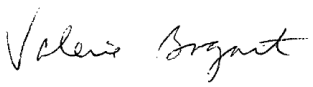
For these reasons, we oppose the restriction on eligibility for MLTC enrollment requiring a minimum number of ADLs. We appreciate New York's efforts around dually eligible individuals and providing pathways to integrated products. We urge New York to ensure that any pathways to integrated products are more than simply a pathway to enrollment in two plans, but rather a pathway to a truly coordinated and integrated care experience.

Thank you for the opportunity to submit these comments.

Very truly yours,



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