January 5, 2024

Chiquita Brooks-LaSure, Administrator
The Center for Medicare and Medicaid
Services 7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of ADvancing States and the National Association of State Directors of Developmental Disabilities Services (NASDDDS), we are pleased to offer comments on the Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS–4205–P).

ADvancing States is a nonpartisan association of state government agencies that represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services (HCBS). Our members administer services and supports for older adults and people with disabilities, including overseeing a wide range of Medicaid HCBS programs. Together with our members, we work to design, improve, and sustain state systems delivering long-term-services and supports (LTSS) for people who are older or have a disability and their caregivers.

NASDDDS represents the nation's state agencies, and the District of Columbia and Puerto Rico, providing services to children and adults with intellectual and developmental disabilities (I/DD) and their families. NASDDDS promotes visionary leadership, systems innovation, and the development of national policies that support HCBS for individuals with disabilities and their families. The NASDDDS mission is to assist member state agencies in building effective, efficient person-centered systems of services and supports. NASDDDS members administer a significant portion of the Medicaid program, managing approximately one third of Medicaid LTSS spending and within that, three quarters of Medicaid HCBS spending.

Key Message

ADvancing States and NASDDDS strongly support the changes proposed in this rule. The current system of care for dually eligible individuals is fragmented, which leads to worse health outcomes and inefficiencies in care delivery that drive increased health expenditures. The proposed changes would help advance the goals of promoting beneficiary choice and facilitating improved access to coverage options. While not the subject of this rulemaking, we feel it is important to stress the need for increased Federal investment in state capacity to effectively implement integrated care activities and in better education for dually eligible individuals.

Section III-- Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

H. Update to the Multi-Language Insert (MLI) Regulation

CMS proposes to update the requirements around MLIs, such that plans would be required to provide MLIs in the 15 most common languages in the state or territory. Under current regulations, plans must provide MLIs in both the 15 most common languages nationally and the 15 most common languages in the state or territory.

We support CMS' efforts to ensure critical information is available to beneficiaries about their Medicare enrollment options. States note that the current regulations, while well-intentioned, often result in confusing and duplicative notice language. One state reports that their MCOs currently send both national and state language blocks, often totaling four pages of attachments to a single-page notice. This is likely confusing to dually eligible individuals and does not provide a clear benefit, as the language blocks are often duplicative and include languages not commonly spoken in the state or territory. The proposed change would streamline information sharing, reduce waste, and make it easier for enrollees to locate important information. We further support the proposal to formally clarify that, if at least five percent of the population in the plan service area speaks a different primary language, plans must also include that language in the MLI. This proposal represents an important safeguard for members with Limited English Proficiency.

I. Expanding Permissible Data Use and Data Disclosure for MA Encounter Data

CMS proposes to allow the release of Medicare Advantage (MA) encounter data to Medicaid agencies to support care coordination for dually eligible members. We strongly support this proposal, which would facilitate enhanced care coordination, more effective quality improvement efforts, and improved D-SNP program design. We note, however, that there are states that do not have systems sophisticated enough to use this data, so

we suggest that MA encounter data be available at the discretion of the state as other Medicare data is.

A range of state stakeholders that work to develop and monitor programs for the dually eligible population can benefit from access to MA encounter data. These include: (1) state Medicaid directors; (2) Medicaid agency teams focused on Medicare-Medicaid integration activities, as well as other areas that impact dually eligible individuals, such as complex care or coordination initiatives, pharmacy and quality management units, finance and program integrity; and (3) state staff at partner agencies, such as aging and disability units that oversee Medicaid-financed or other social service programs that enroll dually eligible individuals.

States can utilize MA encounter data to improve program planning, care coordination, and program integrity for programs serving dually-eligible individuals. These data would allow states and territories to engage in more effective and targeted care coordination. These data would also improve plan design. States could use encounter data to more effectively assess the quality of existing plans, drive quality improvement efforts, assess the usage of supplemental benefits, and design future D-SNP options.

Access to MA encounter data would help ensure program integrity. States can use Medicare encounter data to compare patterns of service use and spending to analyze patterns of fraud or misuse, such as aberrant utilization and/or billing patterns for overlapping benefits to ensure that they do not make inappropriate payments for Medicare-covered services. In addition, states can use Medicare data to ensure individuals with access to Medicare-covered home health benefits are not using Medicaid personal care services at the same time unless there is a demonstrable need for both services.

We strongly support the proposal to allow Medicaid agencies to share these data with their Medicaid accountable care organizations (ACOs) for the purpose of care coordination. In some cases, building data systems and processes for this information would be technically challenging. We recommend CMS provide technical assistance to states to maximize the utility of this encounter data.

Section VIII. Improvements for Special Needs Plans

C. Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services From the Same Organization

1. Changes to the Special Enrollment Periods for Dually Eligible Individuals and Other LIS Eligible Individuals

CMS proposes to replace the existing quarterly special enrollment period (SEP) for dually eligible individuals with two new monthly SEPs: a dual/low-income subsidy SEP that would allow once-per-month enrollment into any standalone prescription drug plan and an

integrated care SEP that would allow once-per-month enrollment into integrated plans.

We focus our comments on the integrated SEP proposal. Medicaid agencies report that the quarterly SEP creates challenges for dually eligible individuals. If an individual's specialist changes networks, for example, the individual may not be able to access that provider until the next SEP opens. Similarly, if an individual chooses a plan that does not appropriately meet their needs (such as a look-alike plan), they can be stuck in that plan for several months while they wait for the next quarterly SEP. CMS's proposed changes would ensure individuals can quickly switch into integrated plans and standalone prescription drug plans when needed. The proposed monthly SEPs would also support CMS's aim of achieving exclusively aligned enrollment (EAE) in D-SNPs by 2030, which will require many dually eligible individuals to move into integrated plans.

However, we note that a significant concern in returning to monthly SEPs – which was the norm until 2018 – is the churn that could be associated with monthly disenrollments. While we support more frequent opportunities for dually eligible individuals to enroll in integrated care options, we do not support creating possibilities for providers to influence individuals' Medicare enrollment choices. We recommend a one-way integrated care SEP, permitting dually eligible individuals to enroll in an integrated care plan once per month but not permitting disenrollments from an integrated care option to Medicare fee-for-service (FFS).

2. Enrollment Limitations for Non-Integrated Medicare Advantage Plans

CMS proposes to limit enrollment in non-integrated MA plans; beginning in 2027, new enrollment in MA plans with Medicaid contracts would be limited to EAE, and beginning in 2030, D-SNPs would only be allowed to enroll individuals who are enrolled in the affiliated Medicaid MCO.

While we understand and support the goals of driving Medicare enrollment to integrated care programs, the primacy of Medicare enrollment choices over Medicaid enrollment choices is concerning. Medicaid agencies note that this proposal could have significant impacts on their MCO markets. In EAE states, an individual's Medicaid managed care enrollment will follow the member's D-SNP enrollment. Given the marketing freedom that D-SNPs have, we worry this proposal could lead to disruptions in a state's Medicaid MCO market. For example, if 80 percent of dually eligible individuals select one D-SNP, those individuals must be moved (to maintain EAE) to the companion MCO, which could lead to unbalanced enrollment in the Medicaid managed care program. That would be of significant concern to Medicaid agencies. We recommend that CMS take these possibilities into account and work with states where this might occur.

CMS proposes to limit how many D-SNPs can be offered by MA organizations, with an exception for D-SNPs required to serve specific eligibility groups designated by the State Medicaid Agency Contract (SMAC). We support this change, as it will simplify plan options and significantly reduce confusion for individuals. The proposed change would also make

it easier for states to track enrollments, coordinate care, and perform quality improvement with their plans. We appreciate the exception for D-SNPs that are required to serve specific eligibility groups, as designated by the SMAC; this flexibility would preserve states' ability to design D-SNPs to meet specific populations' needs.

D. Comment Solicitation: Medicare Plan Finder and Information on Certain Integrated D–SNPs

Medicare has launched Medicare Plan Finder (MPF), a tool that allows individuals to compare MA and Part D plans. MPF currently includes limited information on D-SNPs but does not include information on Medicaid benefits provided through these plans. For Applicable Integrated Plans (AIPs), D-SNP enrollment is limited to EAE. CMS is interested in adding to MPF information about Medicaid-covered benefits in AIPs, such as dental, non-emergency transportation, and certain types of HCBS. We strongly support this proposal. Making information about available plans and their benefits easily accessible to dually eligible individuals will support them in making informed choices regarding plan enrollment and reduces their vulnerability to misleading marketing tactics.

If CMS adds information about AIPs to the MPF, it will be important to keep the site up-to-date and ensure that Medicaid benefit descriptions are accurate. To ensure MPF information is accurate, CMS should allow state Medicaid and operating agencies to review draft benefit descriptions before they are posted and create clear processes for communicating benefit changes. We also encourage CMS to engage with impacted D-SNPs to make the Medicaid benefit data collection process as smooth as possible.

CMS highlights the My Care My Choice website, which showcases integrated care plan options in three states, and seeks comment on any features from the website that may be helpful to dually eligible members. States generally report positive views of the My Care My Choice website. The website is user-friendly and conveys complex information in an understandable way. Specifically, we believe the layout and organization of information on the website (e.g., division of "Find Care", "Understand Your Care," and state-specific "Care Choices") is clear and easy to follow.

E. Comment Solicitation: State Enrollment Vendors and Enrollment in Integrated D–SNPs

1. Current Opportunity for Use of State Enrollment Vendors for Enrollment in Integrated D–SNPs

CMS outlines the existing option for states to utilize Medicaid enrollment vendors for enrollment in integrated D-SNPs. They seek comment on this opportunity, including any concerns CMS should consider with states requiring D-SNPs to route enrollment through the state enrollment vendor and any type(s) of technical assistance that would be helpful to states. While we support this option for states, we specifically note the additional costs that would be incurred by states to compensate its enrollment vendors for their enrollment

activities, since payment for these activities by the D-SNPs themselves would pose a conflict under current Medicare regulations. Moreover, we believe the process of developing and implementing an integrated enrollment process poses operational challenges, including aligning across Medicare and Medicaid enrollment timelines, establishing file submission processes across Medicare and Medicaid, and supporting transitions between programs when needed. We would expect that CMS would make lessons learned from the FAI demonstrations readily available to any state who wishes to take up this option in their SMAC.

2. Medicaid Managed Care Enrollment Cut-Off Dates

CMS highlights challenges to aligning Medicare and Medicaid enrollment start and end dates, noting that some states employ enrollment cut-off dates, or dates after which enrollment in a Medicaid managed care plan is not effectuated until the first calendar day of the next month after the following month. CMS requests input on state reasons for implementing Medicaid managed care enrollment cut-off dates and the barriers to aligning Medicare and Medicaid managed care enrollment start and end dates.

We understand that states implement cut off dates due to operational barriers. For example, if an individual becomes eligible for MCO enrollment on November 30, it is virtually impossible for the MCO to receive that enrollment and be ready to deliver services beginning December 1. By delaying the enrollment start date to January 1, the state can ensure that the individual receives an ID card and access to assistance from the MCO to access covered benefits. While awaiting MCO enrollment activation, the individual has access to Medicaid services through the default FFS system.

Regarding barriers, states cite systems limitations as a significant barrier to integrating enrollment processes. We believe changes to the SEP to allow individuals to enroll monthly for integrated plans would help reduce current barriers to aligning enrollment; however, as noted above, we recommend against allowing monthly disenrollment.

G. Contracting Standards for Dual Eligible Special Needs Plan Look-Alikes

CMS proposes to lower the threshold for D-SNP look-alike plans, such that Medicare Advantage plans with at least 60 percent of their members also enrolled in Medicaid would be considered look-alike D-SNPs. We support this change, as it will better protect dually eligible individuals and support states' efforts to drive integration.

States report serious concerns over D-SNP look-alike plans. Look-alike plans often use aggressive and misleading marketing tactics, including advertising zero premium options with many supplemental benefits; one state notes particular concern over D-SNP look-alike plans advertising in nursing facilities. These marketing tactics can make these plans appear attractive to individuals, but, as CMS notes in the rule, look-alike plans do not provide the protections and integration of actual D-SNPs. This means many dually eligible individuals are being steered away from the integrated D-SNPs that are best equipped to

meet their needs. This hurts dually eligible individuals and undermines Medicaid agencies' long-standing efforts to drive integration.

In the rule, CMS proposes to lower the look-alike threshold to 70 percent for contract year (CY) 2025 and to 60 percent for CY 2026. CMS seeks comment on alternative approaches, including lowering the threshold to 50 percent.

We support lowering the look-alike threshold to 50 percent in CY 2025. A reduction to 50 percent as soon as practicable would clearly signal CMS's intent and may encourage look-alike plans to begin transitioning dually eligible individuals to integrated plans through the proposed monthly SEPs and the proposed transition authority.

H. Limit Out-of-Network Cost Sharing for D-SNP PPOs

CMS proposes new limits on out-of-network cost-sharing for D-SNP Preferred Provider Organizations (PPOs). We support these proposed limits, which would reduce inappropriate cost-shifting to states and offer important protections to dually eligible individuals. As CMS notes, cost sharing for out-of-network services in D-SNP PPOs is often significantly higher than cost sharing for the same services under Traditional Medicare. In the claims data cited by CMS, out-of-network services are often subject to coinsurance rates between 20 and 50 percent. This means states are often paying rates up to 50 percent higher than Traditional Medicare. CMS's proposed limits on out-of-network cost-sharing would prevent this inappropriate cost-shifting, allowing states to use their limited resources more effectively.

The proposed limits on out-of-network cost-sharing for D-SNP PPOs would also be beneficial for individuals and providers. Dually eligible individuals must already navigate a complex system of overlapping benefits and challenges to identify which providers are out-of-network. By limiting out-of-network cost-sharing, CMS would protect dually eligible individuals – who are typically living on very limited income – from out-of-pocket costs. This change may also encourage providers to serve dually eligible individuals, as under the current regulatory framework, out-of-network providers serving D-SNP PPO enrollees in states/territories that limit cost-sharing may receive lower reimbursement.

We appreciate the opportunity to provide comments on this important subject and look forward to continued partnership between CMS and state and territorial agencies in furtherance of our mutual goals to support and improving services for dually-eligible individuals. If you have any questions regarding this letter, please feel free to contact Rachel Neely at rneely@advancingstates.org or Dan Berland at dberland@nasddds.org.

Sincerely,

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