March 7, 2022

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

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to the Center for Medicare and Medicaid Services' (CMS) CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P).

The proposed rule would have significant impacts on the provision of care for dually eligible Medicare-Medicaid members. In general, NAMD is supportive of the proposed rule's aim of promoting care integration for these members and many of the outlined provisions. However, some provisions in the proposed rule may lead to increased administrative burden for state Medicaid programs, disruptions in care for members, and other operational challenges. We also note that these proposals are likely to be most impactful for states that are relatively further along in their duals integration strategies. We encourage CMS to continue its efforts through the Medicare-Medicaid Coordination Office, the Integrated Care Resource Center, and other avenues to promote duals integration strategies for states newer to this complex policy area.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Additional Support for States is Necessary to Maximize Impact

The potential of the proposals in this rule can only be maximized by states with significant internal agency Medicare expertise and capacity to execute on the regulatory tools CMS may offer. Not all Medicaid agencies currently possess this capacity, and recent experience in states seeking to build this capacity shows it is not a trivial undertaking.

Fortunately, robust federal technical assistance opportunities make a difference. NAMD recommends that CMS continue to bolster these resources for states should the proposals in this rule become final. Not all states are similarly situated to leverage the

opportunities on offer here, and CMS should continue its work to build state capacity to develop, sustain, and benefit from new federal flexibilities.

D-SNP Enrollee Advisory Committees

NAMD supports CMS's proposals for Medicare Advantage (MA) organizations to establish enrollee advisory committees if they offer a duals special need plan (D-SNP) product. We agree with CMS's views that such committees will play important roles in communicating enrollee perspectives on plan functionality, the impact of integration, and the identification of barriers to achieving the goals of said integration.

We recommend that the requirement for at least one enrollee advisory committee be a floor rather than a ceiling. States should have the ability to further direct committee geographic scope, composition, and other factors beyond the federal minimum requirement for a committee being established, including requiring multiple committees for specific enrollee populations.

While we recognize that some D-SNPs will already meet the proposed federal requirements due to compliance with the Medicaid managed care rule and other D-SNPs may be variably able to establish multiple committees, there is value in having committees focused on specific populations of served enrollees which may be lost if a singular committee is attempting to address all aspects of diverse enrollee experience.

We further recommend that states have access to the proceedings and recommendations of D-SNP enrollee advisory committees in their states on at least a quarterly basis. This will allow states as well as plans to take into account the insights shared from enrollees to further enhance program offerings.

Standardized Questions on Health Risk Assessments

In general, NAMD is supportive of the proposed requirement to include questions related to housing, food insecurity, transportation, health literacy, and social isolation in health risk assessments. The needs of duals are often complex and sit both within and outside the Medicaid program. Requiring managed care plans to assess the needs of these populations and utilize that information to appropriately manage the whole person is an important policy objective to advance.

In some states, different stakeholders – including managed care organizations, accountable care organizations, and providers – are already required to conduct similar assessments of health-related social needs. To avoid duplication or assessment fatigue, CMS could allow health plans to leverage community or provider organizations to complete these assessments. CMS could also require domains of questions, instead of specific questions, to reduce disruption or duplication and allow more flexibility in targeted assessment questions. CMS could also provide recommended or example questions to reduce burden on states who do not already require the collection of similar information and to ensure sufficient implementation time for plans. Lastly, states should have the authority to require their own questions or domains to align with specific state policy objectives.

Integrated Materials and Unified Grievances and Appeals

NAMD supports CMS's policy proposals in both of these areas. Integrated marketing materials and notices around documents like Evidence of Coverage, Summary of Benefits, List of Covered Drugs, and related materials is valuable for clearly articulating member benefits across Medicare and Medicaid. Unified grievances and appeals processes for FIDE-SNPs both create administrative efficiencies for the states and a simpler pathway for member concerns to be addressed, though appropriate implementation timelines of at least one year will be necessary to implement CMS requirements. Development of standard model material templates could be helpful here to promote consistency across plans.

FIDE SNP Exclusively Aligned Enrollment and Medicare Cost-Share Capitation

Broadly, NAMD supports the proposal for FIDE SNPs to have exclusively aligned enrollment starting in program year 2025. We agree with CMS's analysis suggesting minimal disruption to existing arrangements from this requirement, with ample fallback options for HIDE SNP status for the small number of plans that would be impacted by this change. That said, this goal should be carefully balanced with appropriate member choice of coverage options, with the features of integration clearly articulated by a neutral party to support that choice.

We also support the requirement for requiring FIDE SNP coverage of Medicare cost sharing obligations under Medicaid, which is current practice in all extant FIDE SNPs, as CMS notes.

CMS solicited comment on requiring Medicare cost sharing coverage in all D-SNP platforms. Such a requirement would be much more significant operational challenge compared to limiting cost sharing coverage to FIDE SNPs. For states not already dedicating resources to such an effort, there is a significant learning curve in appreciating the opportunities this policy provides, how it can be operationalized, and how to communicate the benefits to state policymakers. For example, because there is not automatic crossover claims data shared between Medicare Advantage plans and state Medicaid agencies, states must analyze historical crossover claims data to develop accurate capitation rates, which requires significant investment of state resources and staff time.

While capitating cost sharing in D-SNPs can achieve benefits in reducing provider abrasion, increasing member access to services, and expanding the overlap of Medicare and Medicaid provider networks, such benefits cannot be realized if states do not have the capability to implement and sustain the potential cost sharing capitation requirement.

Should CMS at some point in the future require Medicare cost sharing capitation for all D-SNPs, it must be paired with more technical assistance for states and a sufficiently long implementation period to navigate the complexities outlined above.

Required Covered Services in FIDE and HIDE SNPs

We appreciate the detailed discussion and rationale for CMS's proposals around requiring FIDE SNPs to cover all Medicaid primary and acute care benefits, inclusive of home health services, durable medical equipment, and behavioral health services. We also appreciate the clarity around the set of coverage requirements that apply to HIDE SNPs. On the matter of carve-outs, we support the codification of CMS's existing guidance regarding targeted carve-outs of long-term services and supports and/or behavioral health services from FIDE and HIDE coverage to the extent that such services mirror carve-out policy decisions made within the state's Medicaid program. This is an appropriate balance between maximizing integration opportunities through these SNP platforms and retaining flexibility for states to make policy decisions around the scope of benefits they wish to include in their managed care contracts versus remaining directly under the state agency's purview.

Maximum Out-of-Pocket Limits

NAMD is supportive of the changes to the calculation of maximum out-of-pocket limits, which would increase savings for states and create a consistent approach to how such limits are applied across MA plans.

Conversion of MMPs to Integrated D-SNPs

NAMD appreciates CMS's goals in looking to scale successes achieved in the Financial Alignment Initiative demonstration's Medicare-Medicaid plans (MMPs) through the D-SNP platform. As CMS notes, MMPs allow for more tightly integrated financing arrangements and collaboration across Medicare and Medicaid, and significant ability to utilize passive enrollment to place members into integrated care arrangements. These may not be easily replicable outside of an MMP environment. As a result, NAMD recommends that CMS work with states to develop a pathway to allow states to operate MMPs as a state option through a combination of Medicaid and Medicare waiver authorities rather than limit states to the less integrated FIDE SNP structure.

States with MMPs have invested significant resources in building fully integrated plans. Transitioning MMPs to less integrated FIDE-SNPs not only comes at the potential cost of less integrated care for beneficiaries, but also places significant financial and administrative burdens on the state. One state's actuaries estimate that transitioning from MMPs to FIDE-SNPs will have a fiscal impact of $30 to $55 million in state share. Their actuaries' analysis found that requiring FIDE-SNPs to cover benefits traditionally covered by Medicaid as supplemental Medicare benefits was not enough to make up for the loss of shared savings being generated through the fully integrated MMP.

Transitioning from MMPs to FIDE-SNPs will also increase administrative burdens for states. For example, without the MMP integrated enrollment model, the responsibility falls solely on the state to keep enrollment in the Medicare and Medicaid components of the FIDE-SNP or other integrated D-SNP aligned. This change adds additional administrative burden on the state while increasing the risk of misalignment in enrollment in both the Medicare and Medicaid sides of the D-SNP.

CMS also should carefully consider how the potential transition from MMP to integrated D-SNP will interact with states that have highly leveraged the MMP model and its unique characteristics. There are a variety of operational factors to consider and potential impacts on existing MMP enrollees that must be carefully safeguarded against.

As a practical matter, states will need clear guidance on the timelines over which this transition would occur. It would be helpful for the states to have additional information on the contracting, operational, and fiscal modeling involved in such a transition. For example, clear guidance on the responsibilities specific to Medicare, to Medicaid, and those that are shared across programs would be valuable. A readiness checklist prepared by CMS with clear guidance on what states should be considering in preparation the transition away from the MMP model to the FIDE model would better position states that do not have experience with a FIDE model. Another major consideration is stakeholder engagement. It will be critical to begin to inform the broader stakeholder community and gain their input and feedback before, during, and after such a transition. Transitions may take two or more years in light of these complexities.

Sufficient flexibility on the timing of transition must be offered to account for the existing availability of FIDE or HIDE SNP platforms in the state, and the need to modify state programs, managed care contracts, or other aspects of their Medicaid programs to support a FIDE or HIDE if one is not currently in place. This is not a trivial undertaking. For states that do not yet have FIDE or HIDE options, the possibility that the parent MA organization within the MMP does not receive FIDE or HIDE SNP status could create a point of disruption for MMP enrollees. At minimum, these enrollees should be fully informed of any change in their current coverage and be given the option to remain in the MA parent organization's D-SNP (assuming it has FIDE or HIDE status) or enroll in another option for full benefit duals.

More fundamentally, CMS should carefully consider how a potential transition from MMP to integrated D-SNP will interact with states that have highly leveraged the MMP model and its unique characteristics and how to ensure that significant progress on integration under an MMP model is not lost.

For any path forward, states should have the ability to direct members into delivery systems best designed to support them, including based on continuity in provider relationships and plan performance, with robust member protections including opportunities to opt out. This includes access to funding for ombudsman services and options counseling that some states avail themselves of under the MMP, which is an important element of ensuring non-biased person-centered resources to support members in selecting the coverage options that best meet their needs. In addition, CMS should consider additional strategies and flexibilities to ensure financial viability and to mitigate potential cost-shifting between Medicaid and Medicare that may result from state investments in community-based services and care coordination for dual eligible members, which are most likely to result in Medicare, rather than Medicaid, savings.

CMS should also explore how to continue providing states access to CMS data systems and information available in an MMP, such as the Health Plan Management System. The use of federal waiver authorities in both Medicaid and Medicare to address these issues will be critical should CMS finalize its proposed MMP phase-out.

NAMD appreciates the opportunity to provide these comments. These proposals are broadly positive and give already advanced states additional tools to further the goals of integration. We look forward to working together to improve our country's system of care for dually eligible Medicare-Medicaid members.

Sincerely,

Jami Snyder
NAMD Board President
Director
Arizona Health Care Cost Containment System

Allison Taylor
NAMD Board President-Elect
Director of Medicaid
Indiana Family and Social Services Administration