NAMD
National Association of Medicaid Directors

January 5, 2024

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

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the proposed rule, 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.

The proposed rule includes several provisions that would impact care for individuals who are dually eligible for Medicare and Medicaid. These provisions include policies aimed at increasing the percentage of dually eligible members who receive Medicare and Medicaid benefits through the same managed care organization, limits on out-of-network cost sharing for Dual Eligible Special Needs Plan (D-SNP) Preferred Provider Organizations (PPOs), lower thresholds for D-SNP "look-alike" plans, and changes to Medicare Advantage (MA) data sharing.

NAMD strongly supports these proposed changes. The current system of care for dually eligible individuals is fragmented, which leads to worse health outcomes for members and inefficiencies in care delivery that drive increased health expenditures. The proposed changes would help address these challenges by increasing the percentage of dually eligible members who are enrolled in integrated plans, protecting members from misleading marketing, and supporting Medicaid agencies' ability to coordinate care.

NAMD is a professional community of state and territory leaders who provide health insurance to almost 90 million individuals and families through Medicaid and the Children's Health Insurance Program in each of the 50 states, the District of Columbia, and the U.S. Territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives.

Proposed Policy Changes

NAMD Supports Proposed Changes to Increase the Percentage of Dually Eligible Members Who Are Enrolled in Integrated Care Plans

In the rule, CMS proposes a range of provisions aimed at increasing the percentage of dually eligible members who are enrolled in integrated care plans. **NAMD strongly supports these proposed changes.** As of 2022, only 21 percent of full-benefit dually eligible individuals were enrolled in any type of integrated care model, despite research suggesting associations between integrated care and improved health outcomes. CMS's proposed policy changes would help address this challenge by increasing opportunities for individuals to enroll in integrated care plans, simplifying choices around plan enrollment, and reducing "choice confusion." Medicaid Directors note that, although some of the proposed changes may result in short-term disruptions to care, they would likely drive improved care coordination, access, and health outcomes in the long term.

First, 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. NAMD strongly supports this change. Medicaid agencies report that the quarterly SEP creates challenges for dually eligible members. If an enrollee's specialist changes networks, for example, the enrollee may not be able to access that provider until the next SEP opens. Similarly, if an enrollee 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 that enrollees 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 in D-SNPs by 2030, which will require many dually eligible individuals to move into integrated plans.

Next, 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 exclusively aligned enrollment, and beginning in 2030, D-SNPs would only be allowed to enroll individuals who are enrolled in the affiliated Medicaid MCO. Medicaid Directors generally support this proposal. While some states already require exclusively aligned enrollment, other Medicaid agencies note that this proposal would have significant impacts on their MCO markets. This may lead to short-term disruption for dually eligible individuals who are enrolled in non-integrated plans. In the long-term, however, Medicaid Directors report that this policy would significantly increase the percentage of dually eligible members receiving integrated care, which would likely result in improved care coordination, access to services, and member experience.

Medicaid agencies recommend several strategies to reduce potential disruptions to dually eligible members. First, some states note that they would need to make significant systems changes to allow for exclusively aligned plan enrollment; CMS should consider dedicated resources and an extended implementation deadline for states who face these types of challenges. Next, one Medicaid agency notes that Medicaid members who experience temporary disruption in Medicaid MCO enrollment may be disenrolled from D-SNPs under this proposal. To address this, CMS could require D-SNPs to use the deeming process to keep dually eligible members enrolled, even if they face a time-limited disruption in Medicaid MCO enrollment. Finally, one Medicaid agency notes that many of their D-SNPs may need additional time to offer integrated options. CMS could consider case-by-case extensions to the 2030 deadline in cases when ending contracts with D-SNPs may severely limit member choice or where significant state-level statutory and regulatory change may be necessary to meet these goals.

Finally, 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). NAMD supports this proposal. Medicaid agencies report that this change would impact their managed care markets but would simplify plan options and significantly reduce member confusion. The proposed change would also make it easier for Medicaid agencies to track enrollments, coordinate care, and perform quality improvement with their plans. NAMD appreciates the exception for D-SNPs that are required to serve specific eligibility groups, as designated by the SMAC; this flexibility would preserve Medicaid agencies' ability to design D-SNPs to meet specific populations' needs. Medicaid agencies note, however, that CMS should preserve administrative flexibility in assigning "H-numbers," so that enough H-numbers are available to accurately reflect the different populations within each SMAC.

New Limits on Out-of-Network Cost-Sharing for D-SNP PPOs Would Benefit Medicaid Members and Agencies

In this rule, CMS proposes new limits on out-of-network cost-sharing for D-SNP Preferred Provider Organizations (PPOs). NAMD strongly supports these proposed limits, which would reduce inappropriate cost-shifting to Medicaid agencies and offer important protections to dually eligible members. As CMS notes in the rule, 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 that Medicaid agencies 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 Medicaid agencies 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 Medicaid members and providers. Dually eligible individuals must already navigate a complex system of overlapping benefits and may find it challenging to identify which providers are out-of-network. By limiting out-of-network cost-sharing, CMS would protect dually eligible members – who are typically living on very limited income – from out-of-pocket costs. This change may also encourage providers to serve dually eligible members; 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.

CMS seeks comment on several alternative approaches, including limiting all D-SNP PPO out-of-network cost sharing to no greater than traditional Medicare, only applying cost sharing limits for services for which Medicaid payment did not result in a total payment that was at least equivalent to the payment under Traditional Medicare, and applying cost sharing limits only for Qualified Medicare Beneficiary (QMB) enrollees. **NAMD supports either the proposal as written or the alternative proposal to limit cost sharing to no greater than Traditional Medicare.** Medicaid agencies note that the other proposed alternatives would be administratively complex and may not be implemented successfully.

NAMD Supports Stronger Action on D-SNP Look-Alike Plans

In the rule, 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. NAMD strongly supports this proposal. This change would protect dually eligible members and support Medicaid agencies' efforts to drive integration.

Medicaid agencies 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 for enrollees, but, as CMS notes in the rule, look-alike plans do not provide the protections and integration of actual D-SNPs. This means that many dually eligible members are being steered away from the integrated D-SNPs that are best equipped to meet their needs. This hurts dually eligible members 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. **NAMD supports lowering the look-alike threshold to 50 percent in CY 2026.** Medicaid agencies note that 60 percent of a plan's enrollees consisting of dually eligible members represents a significant number of individuals who are not experiencing the benefits of integration. A more ambitious reduction to 50 percent would clearly signal CMS's intent and may

encourage look-alike plans to begin transitioning dually eligible enrollees to integrated plans through the proposed monthly SEPs and the proposed transition authority.

NAMD Supports Proposed Changes to Multi-Language Inserts

In the rule, CMS proposes to update the requirements around multi-language inserts, 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. **NAMD strongly supports this proposed change, which represents a common-sense strategy to simplify notices.**

Medicaid agencies 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. NAMD appreciates CMS's 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 (LEP).

Access to Medicare Advantage Encounter Data Would Support Care Coordination

In the rule, CMS proposes to allow the release of Medicare Advantage (MA) encounter data to Medicaid agencies to support care coordination for dually eligible members. **NAMD strongly supports this proposed change, which would facilitate enhanced care coordination, more effective quality improvement efforts, and improved D-SNP program design.**

Medicaid agencies note the potential benefits associated with access to MA encounter data. First, this data would allow states and territories to engage in more effective and targeted care coordination. This data would also improve plan design; states report that they would 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. Finally, access to encounter data would help ensure that Medicaid agencies are fully compliant with federal requirements around being the payer of last resort.

NAMD strongly supports the proposal to allow Medicaid agencies to share this data with their Medicaid ACOs for the purpose of care coordination. Medicaid agencies do note that, in some cases, building out these data linkages would be technically challenging; CMS should consider providing systems technical assistance to maximize the utility of

this encounter data. CMS seeks comment on the use of MA encounter data to support Core Set reporting. Medicaid agencies note that this data would facilitate Core Set reporting on dually eligible individuals.

Requests for Comments

Adding Information on Medicaid Benefits to Medicare Plan Finder

CMS seeks comment on adding information about certain Medicaid-covered benefits in Applicable Integrated Plans (AIPs) to the Medicare Plan Finder tool. **Medicaid Directors believe this would be helpful to dually eligible members.** Easily accessible information about available plans and their benefits supports dually eligible individuals in making informed choices around plan enrollment and decreases their vulnerability to misleading marketing tactics.

In the rule, CMS seeks comment on the My Care My Choice website, which showcases integrated care plan options in three states. Medicaid agencies report positive views of the My Care My Choice website; the site is user-friendly, clearly conveys complex information, and simplifies choices around plan enrollment. Specifically, Medicaid agencies note that the questions around care coordination and data sharing are very useful, as they translate complex concepts around plan design (e.g., integrated vs. non-integrated SNPs) into clear choices. Medicaid agencies also note that the "next steps" tab is helpful for connecting the individual to the appropriate enrollment site.

If CMS moves forward with adding information about AIPs to the Medicare Plan Finder, it would be important to keep the site up-to-date and ensure that Medicaid benefit descriptions are accurate. One state notes that they sometimes add new benefits off-cycle due to the length of the federal approval process, which can make updating websites more challenging. To ensure that the Plan Finder is accurate, CMS should allow Medicaid agencies to review draft benefit descriptions before they are posted and create clear pathways to communicate benefit changes.

State/Territory Use of Medicaid Enrollment Vendors for Integrated D-SNPs

In the rule, CMS seeks comment on state/territory utilization of Medicaid enrollment vendors for integrated D-SNPs. Although no Medicaid agencies who contributed to NAMD's comments use an external vendor, one state indicated that they have implemented integrated enrollment processes with the state acting as an enrollment vendor. This Medicaid agency notes that they faced several challenges when developing an integrated enrollment process, including aligning across Medicare and Medicaid enrollment timelines, establishing file submission processes across Medicare and Medicaid, and supporting transitions between programs when needed. They report that well-qualified enrollment vendors may be helpful in integrating enrollment processes in other states.

CMS seeks comment on the use of Medicaid managed care enrollment cut off dates. Medicaid agencies report using cut off dates due to operational barriers; if a new member submits their plan enrollment on November 30, for example, it can be very difficult to ensure that the MCO can provide benefits on December 1. By keeping these members in Medicaid fee-for-service until January 1, the Medicaid agency can ensure that the individual does not face gaps in accessing benefits.

CMS seeks comment on barriers associated with aligning Medicaid and Medicare enrollment dates. One state notes that they have already aligned enrollment dates as part of a broader effort to integrate enrollment processes. Other Medicaid agencies, however, report barriers to aligning enrollment dates, including systems limitations; one agency notes that they would need to make substantial fiscal investments to effectuate the needed systems changes. Finally, some Medicaid agencies note that the proposed monthly SEP for integrated plans would significantly reduce current barriers to aligning enrollment dates.

Conclusion

NAMD strongly supports the proposed policy changes in this rule. The proposed changes would increase opportunities for dually eligible individuals to enroll in integrated plans, reduce choice confusion, create new protections against look-alike plans, and enhance Medicaid agencies' ability to coordinate care and improve plan quality. Although some of the changes to D-SNP requirements may lead to short-term disruptions in care, they would likely increase enrollment in integrated care in the long-term, driving improvements in care and member experience. Extended implementation deadlines and dedicated resources may help ameliorate these impacts.

Thank you for the opportunity to provide comments on this proposed rule. NAMD looks forward to continuing to work with CMS to improve the system of care for dually eligible individuals.

Sincerely,

Cynthia Beane, MSW, LSCSW

Cindy Beane
NAMD Board President
Commissioner
West Virginia Department of Health and Human Resources

Lynnette R. Rhodes

Lynnette Rhodes
NAMD Board President-Elect
Executive Director
Medical Assistance Plans Division,
Georgia Department of Community Health