NAMD
National Association of Medicaid Directors

January 26, 2026

Dr. Mehmet Oz
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Dr. Oz:

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the proposed rule, Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program.

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 changes to the Model of Care (MOC) off-cycle submission timing, revisions to passive enrollment, and policy adjustments to allow continued dual-eligible special needs plan (D-SNP) enrollment for Medicaid fee-for-service (FFS) populations in states and territories with voluntary Medicaid managed care. The rule would also clarify CMS' authority to immediately terminate a D-SNP contract when its state Medicaid agency contract (SMAC) ends and would formalize limits on D-SNP-only contracts using multi-contract entity (MCE) submissions.

NAMD generally supports these proposed changes and appreciates CMS' continued focus on strengthening Medicare-Medicaid integration through D-SNPs. Medicaid agencies have made significant investments in recent years to use D-SNPs to reduce fragmented care, improve coordination across Medicare and Medicaid benefits, and promote aligned enrollment for dually eligible individuals. Given persistent variation across states and territories in D-SNP enrollment, the characteristics of the dually eligible population, delivery system design, and provider network capacity, NAMD encourages CMS to preserve flexibility for Medicaid agencies in D-SNP policy. Such flexibility is essential to allow states and territories to tailor D-SNP approaches to reflect local program structures and market conditions while continuing to advance integrated care for dually eligible individuals.

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 (CHIP) 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 the MOC Off-Cycle Submission Window

In the rule, CMS proposes to replace the existing MOC off-cycle submission window of June through November with two off-cycle submission periods per contract year: January 1 through March 31 and October 1 through December 31. **NAMD supports these changes.** This administrative change would eliminate the overlap between the initial and renewal MOC submission deadline and the current off-cycle submission window. NAMD particularly appreciates that the proposal would preserve roughly the same overall amount of time for plans to make updates to their MOC.

CMS Should Balance Passive Enrollment Flexibility with Network Adequacy Protections

In the rule, CMS proposes to make passive enrollment easier by removing the requirement that receiving D-SNPs have "substantially similar" networks and instead requiring at least 120 days of continuity of care and sufficient care-coordination staffing. CMS also proposes to update terminology to ensure passive enrollment applies to plans that meet the definition of applicable integrated plans (AIPs). While NAMD is supportive of approaches to prevent gaps in coverage for dually eligible individuals, some Medicaid agencies have expressed concerns that removing the "substantially similar" network requirement without putting stronger protections in place could make it harder for people to get care, especially in areas where provider shortages already exist.

These Medicaid agencies are concerned that a 120-day continuity-of-care period may be insufficient for individuals with complex needs who rely on long-standing provider relationships and home- and community-based services. **NAMD therefore encourages CMS to provide Medicaid agencies with the flexibility to align them with their existing standards, set higher standards, or require comparable provider networks, if they choose, as a condition of passive enrollment. NAMD also heard from some Medicaid agencies that they would be supportive of an approach that aligns passive enrollment with the SMAC requirements.** Any approach should emphasize flexibility to allow states and territories, particularly those facing ongoing provider shortages in key service areas, such as behavioral health, long-term services and supports, or specialty care, to better protect continuity of care and avoid passive enrollment into plans with weaker or less adequate networks.

Lastly, Medicaid agencies support changes to describe the Medicare Advantage plans that can receive passive enrollment to include plans that operate as AIPs, rather than limiting eligibility to FIDE or HIDE SNPs. For some Medicaid agencies, AIPs do not meet the fully or highly integrated designation due to carve-outs of certain Medicaid services from managed care, yet these plans still provide robust integration and coordination across the full range of Medicare and Medicaid benefits. Because AIPs

operate with exclusively aligned enrollment, agencies view them as meeting one of the most critical elements of an integrated care program and believe this feature should be prioritized over formal integration designations.

NAMD is Supportive of Exempting Territories from the Proposed Changes to Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a D-SNP and Medicaid FFS

NAMD supports the provisions that would exempt the territories from the 2027 requirement to offer only one D-SNP in areas where a plan also operates a Medicaid MCO. Medicaid agencies in the territories appreciate CMS' recognition of the unique Medicaid and Medicare landscapes in these jurisdictions, including distinct financing structures such as the absence of Medicare Savings Programs and Part D low-income subsidies. NAMD agrees that tailoring alignment and enrollment policies to reflect the uniqueness of the territories is critical to preserving access to coverage and promoting program stability and commends CMS for taking a thoughtful and flexible approach that acknowledges the uniqueness of D-SNP operations in the territories.

NAMD Does Not Have Concerns with Contract Modifications for D-SNPs Following SMAC Termination

In this rule, CMS proposes to allow immediate termination of a D-SNP's Medicare contract if it loses its required SMAC, including separating the D-SNP from a broader Medicare Advantage contract when necessary. The rule would also remove an opportunity for a corrective action plan. **NAMD does not have any concerns with this proposal; however, we suggest that CMS align the effective date of the Medicare contract termination with the SMAC termination date established by the Medicaid agency and consult with the Medicaid agency when such terminations occur.**

<u>Request for Information</u>

Medicaid agencies are investing significant amounts of time and limited resources to ensure that dually eligible individuals have access to high-quality, integrated care. While agencies have tools to promote and increase enrollment in integrated products such as D-SNPs, including through SMACs, default enrollment, and exclusively aligned enrollment, they also need effective tools to guard against growth in non-integrated products, particularly chronic condition special needs plans (C-SNPs) and institutional special needs plans (I-SNPs).

Medicaid agencies strongly support CMS' efforts to strengthen oversight of C-SNP and/or I-SNP participation to prevent practices that may circumvent existing D-SNP look-alike contracting limitations. Medicaid agencies encourage CMS to closely monitor trends in C-SNP and/or I-SNP enrollment of dually eligible individuals to promote effective care coordination and advance integrated care for this population. Medicaid agencies express interest in having access to a broader set of tools to promote integration and transparency for dually eligible enrollees, including options for C-SNP and I-SNP data-sharing agreements. In addition, Medicaid agencies in states and territories with

higher levels of C-SNP and I-SNP enrollment indicate that they would welcome CMS sharing data and analyses on national, state, and territory-level enrollment trends that may be relevant.

At the same time, Medicaid agencies are at varying stages of integration and have adopted different approaches to aligning care for dually eligible individuals. As a result, it is critical that CMS offer more than one policy option to address the rapid growth of C-SNPs and I-SNPs, as the effectiveness of any single approach will vary by state based on its integration strategy, delivery system, and existing landscape. The considerations below may further inform future CMS policy development related to C-SNPs and/or I-SNPs.

SMAC Requirements for C-SNPs and/or I-SNPs With High Concentrations of Dually Eligible Individuals

CMS requested input on whether it should adopt a SMAC requirement for C-SNPs and/or I-SNPs with high concentrations of dually eligible individuals, as well as whether to establish related federal requirements for those contracts. Medicaid agencies noted that administering existing SMACs with D-SNPs is already a significant undertaking, and that ongoing workforce and budget constraints significantly limit their capacity to take on additional SMAC responsibilities without additional federal support.

Medicaid agencies acknowledge the potential benefit of a SMAC requirement for C-SNPs and I-SNPs, but only if it is paired with dedicated federal funding to support the additional administrative and oversight responsibilities. In the absence of such funding, agencies emphasized that if CMS pursued this as a policy, it is important for CMS to offer flexible options that would allow states and territories to pursue alternative coordination arrangements tailored to their delivery systems and integration strategies. These options could include developing coordination agreements similar to SMACs that would allow for enhanced care coordination and oversight of shared Medicaid members. These agreements could include requirements for data sharing between Medicaid agencies and plans, sharing of MOC plans with relevant state and territorial entities involved in service coordination, alignment with D-SNP look-alike plans if the membership is 60% dually eligible, additional administrative coordination to address duplication of payment, overlap of services, and identification of shared high-need individuals. **CMS should consider technical assistance opportunities to support Medicaid agencies in meeting these goals in an administratively streamlined manner.**

Care Coordination Requirements for Dually Eligible C-SNP and/or I-SNP Enrollees

CMS requested input on whether they should adopt new care coordination requirements for dually eligible C-SNP and/or I-SNP enrollees, add any MOC requirements for these SNP types, and what those care coordination or MOC requirements should include. **Medicaid agencies indicated interest in policies that would establish additional care coordination expectations for C-SNPs and I-SNPs, particularly if they are required to coordinate with Medicaid managed care plans.** Medicaid agencies would benefit from a flexible approach that allows them to determine how those expectations

are operationalized, rather than relying on prescriptive or duplicative requirements. This flexibility would help minimize administrative burden and allow Medicaid agencies to align oversight with existing program structures.

Applying D-SNP Look-Alike Threshold to C-SNPs

CMS requested input on whether certain limits that currently apply to "D-SNP look-alike" plans should also apply to C-SNPs with a high percentage of dually eligible members. **Medicaid agencies expressed receptivity to apply similar limits to C-SNPs, consistent with CMS' approach to D-SNPs, with key exceptions.** Specifically, Medicaid agencies reported excluding C-SNPs that target end-stage renal disease, HIV/AIDS, and chronic mental health conditions, as well as excluding partial-benefit dually eligible individuals from the look-alike threshold to allow their continued enrollment in C-SNPs, particularly in states and territories where partial duals cannot enroll in D-SNPs.

Medicaid agencies noted that individuals with these especially complex conditions may be well served by C-SNPs that offer tailored models of care and benefit packages, making it appropriate to retain these plans as an option for dually eligible beneficiaries who choose to enroll. However, for C-SNPs targeting other conditions, Medicaid agencies reported limited added value compared to integrated D-SNPs and therefore supported applying the look-alike threshold to those plans.

If these policies are implemented, **Medicaid agencies indicated that additional CMS guidance would be helpful for the agency and plans**. This includes expanded resources for State Health Insurance Assistance Program (SHIP) counselors to help members understand the differences between D-SNPs and C-SNPs and how each option may best meet an individual's needs. **Any new policies should also include ample time for Medicaid agencies to prepare and effectively communicate and implement changes.**

Improving Access and Care Coordination to Support Serious Mental Illness and Substance Use Disorder

Medicaid is the largest payer for mental health services in the U.S. and an increasingly significant payer for substance use disorder services. NAMD appreciates CMS' continued interest in identifying ways to improve access to treatment and care coordination for individuals with these needs. In discussions with Medicaid agencies, one agency strongly considers integrated D-SNPs to be the best mechanism to address the behavioral health conditions among dually eligible individuals, particularly those under age 65 for whom these needs may be significant. CMS could consider whether adjustments to risk adjustment methodologies could better reflect the complexity and intensity of care required for this population. **NAMD also encourages CMS to engage NAMD members and other relevant stakeholders to identify mechanisms to improve behavioral health outcomes for dually eligible individuals.**

Thank you for the opportunity to provide comments on this proposed rule. NAMD looks forward to continuing to work with CMS to improve care for Medicaid members.

Sincerely,

Melisa Byrd
NAMD Board President
Medicaid Director
DC Department of Health Care Finance