MEDICARE-MEDICAID
INTEGRATION ALLIANCE

January 27, 2025

The Honorable Jeff Wu
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Wu:

The Medicare-Medicaid Integration Alliance (MMIA) is a group of aligned organizations aimed at improving healthcare and services for people who are dually eligible for Medicare and Medicaid. The purpose of this letter is to comment on the "Contract Year 2026 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" proposed rule (CMS 4208-P) that was issued by CMS on November 26, 2024 in the Federal Register.

First, we want to thank the agency for the important work it does to improve the Medicare and Medicaid programs for this important population, including its efforts to advance care integration and the beneficiary experience through Medicare Advantage. Policies and programs designed to improve care delivery for people who are dually eligible are critical to meet their complex medical, functional, and social needs.[1] Medicare and Medicaid were not designed to work together, and beneficiaries who enroll in both programs often face fragmented care, administrative inefficiencies, and confusing coverage rules. Furthermore, they also account for a disproportionate share of spending in both programs.[2]

While integrated care approaches under Medicare Advantage that are driven by State Medicaid Agency Contracts (SMACs) with Dual Eligible Special Needs Plans (D-SNPs) continue to innovate to address these challenges, many people who are dually eligible and their providers are still impacted by fragmented and uncoordinated care. MMIA supports changes to advance policies that maximize integrated, person-centered care experiences for these beneficiaries to help mitigate the challenges due to misaligned care.

Given MMIA's policy focus on people who are dually eligible, we limit our comments on the proposed rule to those sections most directly related to this population. These sections include:

- Improving Experiences for Dually Eligible Enrollees
- Promoting Informed Choice- Expand Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap
- Administration of Supplemental Benefits Coverage Through Debit Cards
- Medicare Advantage Network Adequacy
- Ensuring Equitable Access – Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures

While all of the signatories to this letter support the recommendations outlined, some signatories may submit separate letters to CMS on this proposed rule that may be broader in scope or provide more specific recommendations on each topic.

More detailed comments follow.

V. Improving Experiences for Dually Eligible Enrollees

Member ID Cards, Health Risk Assessments, and Individualized Care Plans

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[1] ATI Advisory. A Profile of Medicare-Medicaid Dual Beneficiaries.

[2] MACPAC. Dually Eligible Beneficiaries

Background: CMS proposes several new requirements for D-SNPs that meet the requirements for Applicable Integrated Plans (AIPs) to reduce administrative burden and for members, limit some of the duplication that they experience across their Medicare and Medicaid coverage. Specifically, CMS is proposing to require AIPs to: 1) have integrated member identification (ID) cards for both of the enrollee's Medicare and Medicaid plans, 2) conduct an integrated health risk assessment (HRA) that meets both Medicare and Medicaid requirements, and 3) strengthen the individualized care plan (ICPs) process by giving enrollees and their caregivers more control over their health care.

Policy Position: We strongly support CMS' proposal to require AIPs to provide one integrated member ID card and conduct an integrated HRA. We also strongly support CMS' proposed improvements to the ICP.

Justification: The misalignment between the Medicare and Medicaid programs creates significant challenges for people who are dually eligible, providers, plans, states, and CMS. In addition to poor health outcomes and care experiences, challenges include administrative inefficiencies related to coordination and duplication of services across programs, overlapping costs which can drive spending for an already high-cost population, provider confusion, and federal and state oversight burdens.[3] CMS' proposals to integrate the member ID cards and HRAs can further streamline care delivery and program administration and increase states' ability to manage and oversee AIPs. Additionally, the proposed "person-centered" ICP specifications provide guidelines to help ensure that enrollees have agency over their health care decisions and the ability to drive their own care alongside their providers. Finally, as CMS highlights, these efforts would carry over best practices from the sunsetting Medicare-Medicaid Plans (MMPs), which stand as a preeminent model for integrated care.

We are supportive of CMS limiting these requirements to AIPs, as operationalizing a single ID card and HRA is significantly easier to implement when all plan enrollees receive care from the same organization. Of note, these requirements would also apply to all Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) in 2030 as they will be required to meet AIP criteria.

Assuring Enrollee Advisory Committee Input on MOC Updates

Background: As of contract year 2023, Medicare Advantage organizations (MAOs) offering one or more D-SNPs in a state must establish and maintain one or more enrollee advisory committees (EACs) that serve the D-SNPs offered by the MAO in that state. These EACs must include a reasonably representative sample of enrollees, or other individuals representing those enrollees.[4] In the proposed rule, CMS emphasizes that enrollees should have a voice in the development of D-SNPs' Model of Care (MOC). All D-SNPs are federally required to establish and follow an MOC, which provides a basic framework for how the plan is to meet the unique needs of each enrollee through its care management and care coordination processes.[5] Specifically, CMS states that enrollees should have input on how the D-SNP conducts HRAs and ICPs. CMS asserts that enrollee feedback on the MOC would improve how D-SNPs engage enrollees in conducting HRAs and ICPs, the quality of information obtained from these enrollees, and the usefulness of the HRAs and ICPs in improving care coordination and supporting enrollees' health care. Specifically, CMS proposes to require that EACs include updates to MOCs among the minimum required EAC discussion topics.

Policy Position: We support requiring D-SNPs to obtain enrollee feedback on the MOC, including how the HRA and ICP are conducted, to ensure these care management tools empower enrollees, their caregivers, and providers over how their health care is delivered.

Justification: D-SNP EACs present an opportunity for plans to engage with enrollees and gather feedback directly from their members making it a logical place to require D-SNPs to collect feedback from enrollees on the MOC, HRA, and ICP. Regardless of how information is collected, obtaining enrollee feedback on the MOC, HRA, and ICP helps ensure that these tools are central to the care delivery framework and developed in ways that provide enrollees with autonomy over their coverage. For enrollees to participate fully and ensure productive discussions, however, they may need additional supports

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[3] Penn LDI. White Paper: Forging a Path Toward Integrated Care for Dually Eligible Individuals.

[4] Medicare-Medicaid Coordination Office. Lessons Learned from Dual Eligible Special Needs Plans Enrollee Advisory Committee Strategic Conversation. June 2024.

[5] CMS. Model of Care (MOC)

and education on these plan elements. For example, participants may be unaware of the purpose, details, and impact that these tools have on care delivery which are important factors in their ability to offer constructive input. To support plans with this engagement CMS could produce model materials or guidance for plans outlining how to best educate and inform enrollees to ensure these discussions are productive. CMS should also consider beneficiary educational needs as it develops oversight mechanisms to promote transparency around enrollee input and guarantee that beneficiaries can productively contribute to program design discussions.

Comment Solicitation – Making State Medicaid Agency Contracts Public

Background: The SMAC is an agreement that each D-SNP must have with the state in which it operates. The SMAC dictates plan requirements, including expectations around coordinating enrollees' Medicaid coverage alongside delivering Medicare-covered services. States often leverage SMACs to promote state priorities and advance care delivery models and approaches for their dually eligible population. In the proposed role, CMS is seeking comments on whether and how CMS should post SMACs online.

Policy Position: We strongly support making SMACs publicly available and encourage CMS to ensure that any collection and online posting of SMACs are minimally burdensome for states.

Justification: Making SMACs—and thus state program design decisions regarding their D-SNP program—publicly available supports program integrity and allows states to learn from each other which can help move integration forward at a large scale. Anecdotally, states report struggling with how to best use these contracts to create alignment between their Medicaid programs and the Medicare program. Making SMACs public supports peer learning and can help states advance and manage their own programs by borrowing language from other state's contracts. From a program integrity perspective, creating an opportunity for advocates, researchers, and other stakeholders to easily review SMACs across states allows them to study the design of states' plans, which can hopefully lead to broad program improvements and greater alignment among D-SNPs across the country. It would be helpful for CMS to consider how it could assist in categorizing/organizing publicly posted SMACs. For example, CMS could separate and post contracts for partial-benefit dually eligible individuals, full-benefit dually eligible individuals, or contracts for D-SNP programs serving individuals over age 65 or under age 65, to help states and other stakeholders clearly identify SMACs of interest. Further, as CMS acknowledges, it is critical to ensure that sensitive or confidential information is redacted; however, it is also important to keep as much information public as possible to maintain the integrity of the proposal. Finally, we strongly encourage CMS to consider how to make this request of states as simple and straightforward as possible.

O. Promoting Informed Choice – Expand Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap

Background: CMS proposes to require that agents and brokers of first tier, downstream, or related entities (FDR) discuss Low-Income Subsidy (LIS), the Medicare Savings Program (MSP), and Medigap with potential enrollees during the marketing and sale of plans prior to new enrollments. Specifically, agents and brokers would be required to identify relevant resources for the beneficiary regarding LIS and MSP, including eligibility and application support. They would also be required to discuss the potential impact of Medicare Advantage enrollment on guaranteed issue rights under Medigap (i.e., after being enrolled in a Medicare Advantage plan for more than one year, the enrollee may not be able to obtain Medigap coverage unless they are in a state with federal guaranteed issue rights).

Policy Position: We are supportive of requiring that agents and brokers ensure beneficiaries are made aware of and educated about LIS, MSP and Medigap.

Justification: It is critical that beneficiaries are supported in making informed decisions about their health care coverage. This includes understanding the impact that enrolling in a Medicare Advantage plan may have on access to other benefits like LIS, MSP, and Medigap, as well as their eligibility for these benefits generally. Requiring agents and brokers, who are important sources of information for beneficiaries, to educate potential enrollees about these programs is a vital responsibility to ensure that they are supporting individuals in good faith through the enrollment process. Therefore, we are supportive of specifying that agents and brokers meaningfully inform beneficiaries about the LIS, MSP, and Medigap programs, including discussion about their benefits, potential eligibility, and how they may intersect (and create potential tradeoffs) with Medicare Advantage enrollment. We encourage CMS to consider additional ways to ensure that education around these programs is helpful, clear, and meaningful to beneficiaries to ensure they're effective. For example, CMS may consider providing model language or alternative resources for what these discussions on LIS, MSP, and Medigap should cover to clarify how information should be communicated in plain language. Given this attention on efforts to further educate agents and brokers, we encourage CMS to also consider opportunities for supporting State Health Insurance Assistance Programs (SHIPs) and their ability to guide informed decision-making as they too are a critical enrollment resource for beneficiaries.

F. Administration of Supplemental Benefits Coverage Through Debit Cards

Background: CMS is seeking to provide clarity on the use of debit cards as supplemental benefits. CMS' proposal would require MAOs to implement transparency measures regarding rules around supplemental benefits and debit cards, ensure that debit cards are electronically linked to covered items and services, and clarify what over the counter products are acceptable for purchase with these cards. CMS also proposes to prohibit MAOs from marketing the dollar value of supplemental benefits or the method by which a supplemental benefit is administered.

Policy Position: We agree that additional guardrails and transparency around debit cards are needed, in addition to greater transparency on supplemental benefits generally to ensure that beneficiaries can make informed enrollment decisions and understand their total suite of services once enrolled.

Justification: MAOs use taxpayer dollars to make supplemental benefits available to Medicare beneficiaries; CMS estimates that supplemental benefits and premium buy-downs will total more than $79 billion in 2026.[6] CMS also reports that MAOs regularly use debit cards as supplemental benefits and that it has received various questions from stakeholders (including Medicare beneficiaries) around how these cards work. We are concerned that the dollar value of debit cards today can inadvertently increase income and impact dually eligible enrollee's eligibility for other safety net programs (e.g., Supplemental Security Income). Given the significant cost, stakeholder confusion, and financial implications on Medicare enrollees, it is critical from a program integrity perspective that CMS continue to work with stakeholders, including advocacy groups and Medicare Advantage plans, in furthering Special Supplemental Benefits for the Chronically Ill (SSBCI) transparency efforts from both this year's proposed final rule and from that which was laid out in 2025. [7,8]

N. Medicare Advantage Network Adequacy

Plan Benefit Package Level Reviews

Background: Currently, CMS has regulatory authority to conduct network adequacy reviews at the plan benefit package (PBP) level, but in practice conducts these reviews at the contract level. In the proposed rule, CMS suggests leveraging this authority by conducting network adequacy reviews and applying time and distance standards at the PBP level as opposed to the contract level.

Policy Position: We are supportive of policies that ensure provider networks are adequate to serve people who are dually eligible. Therefore, we believe that conducting network adequacy reviews and applying time and distance standards at the PBP level would more accurately reflect local markets and may do a better job of ensuring adequate access to providers.

Justification: D-SNPs often operate as separate benefit packages under a larger MAO contract that may include non-D-SNPs, with provider networks that may vary across plans. Given this, conducting network adequacy reviews at the contract level may obfuscate the adequacy of D-SNP networks or any plan-specific network. This can present challenges for enrollees who are not able to access needed services because the approved networks may not include sufficient providers at the local level. It can also pose challenges for states who are tracking and trying to improve access to care for dually eligible enrollees in D-SNPs or other MAOs. States may not be able to identify gaps in access to services for some of the most vulnerable

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[6] CMS. Fact Sheets: Contract Year 2026 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 (CMS-4208-P).

[7] GAO. Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization.

[8] CMS. Fact Sheet: 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 (CMS-4205-F)

residents if network adequacy data does not accurately reflect local, PBP-specific experiences. Reviewing networks at the PBP level could mitigate this lack of transparency.

M. Ensuring Equitable Access – Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures

Background: The 2025 proposed rule required Medicare Advantage plans to conduct an annual aggregated analysis on the use of prior authorization across populations with specified social risk factors (SRFs) to assess how prior authorization practices impact people who are dually eligible, LIS recipients, or those with a Medicare disability. In the current proposed rule CMS suggests revising the required metrics so they are reported by each covered item and service to allow for disaggregation and greater granularity to better assess the impact of prior authorization practices on the three stated populations. CMS would require that the results of the analysis include an executive summary to provide additional context, clarifying information, and an overview of the information including key statistics and results.

Policy Position: We strongly support additional transparency related to utilization management tactics employed by MAOs and believe it is important that the impact of these tactics on people who are dually eligible is clear. Therefore, we are supportive of CMS' intentions related to utilization management policies, procedures, and information. Importantly, however, we also recognize that there are several ways that information could be collected and shared to reduce administrative burden for plans, ease CMS reporting and review of the data, and maximize the utility of the information.

Justification: Making utilization management data available for discrete populations, including people who are dually eligible, is important for CMS oversight, increased transparency for Medicare stakeholders, and to help plans target quality improvement activities and hold them accountable for coverage decisions. In addition, this information is important for states to better understand whether a Medicare Advantage plan's utilization management practices impact the dually eligible population differently than their Medicare-only counterparts, and whether these differences result in worse access and care experiences for the dually eligible population. It may also provide better insight for states that contract with D-SNPs to identify new ways that plans can improve access to care. To make data collection more feasible for plans and to have the most useful information – especially for enrollees – CMS could consider how: (1) items and services can be grouped into general categories to avoid a burdensome analysis that requires reporting by every covered item and service; and/or (2) to allow plans to report this information through encounter data rather than collecting and disaggregating required data.

Thank you in advance for your consideration. We are more than happy to meet with you to discuss these recommendations and answer any questions you may have. Please reach out to Amy Abdnor at aabdnor@arnoldventures.org or Michelle Herman Soper at michelle@atiadvisory.com with any questions.

Sincerely,

Arnold Ventures
Community Catalyst
Families USA
Justice in Aging
LeadingAge
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SNP Alliance