March 7, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-4192-P Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 Fed. Reg. 1842 (January 12, 2022).

Over the past several years, the Commission has engaged in many conversations regarding integrated care programs for individuals dually eligible for Medicaid and Medicare. It is our strongly held view that furthering integration has the potential to improve beneficiary outcomes and promote more effective and efficient coordination between Medicaid and Medicare, potentially reducing spending and promoting equity. Our work has focused on three goals: increasing enrollment in integrated products, making integrated products more widely available, and promoting greater integration in existing products.

The Commission discussed this proposed rule at our January 20, 2022 public meeting, as it would make a number of policy changes relevant to integrated care programs that are of interest to us. In particular, many of the changes are intended to promote integration of care for dually eligible beneficiaries by applying features of the Medicare-Medicaid plans (MMPs) operating under the Financial Alignment Initiative (FAI) to Medicare Advantage (MA) dual eligible special needs plans (D-SNPs).

The Commission generally supports the changes in the notice of proposed rulemaking affecting dually eligible beneficiaries and applauds CMS for

putting forward many policy changes designed to improve integration for the dually eligible population. However, the proposed rule addresses only one of our three goals for integrated care. While these policy changes promote integration in existing products, they do not necessarily increase the availability of integrated models or enrollment in integrated plans. In future rulemaking, we urge CMS to look for ways to expand policies to promote integration beyond D-SNPs with exclusively aligned enrollment (plans where the same entity is responsible for all Medicaid and Medicare benefits for its members) so that more beneficiaries have access to them.

Finally, we consider federal support to states to be critical to successful implementation of the changes in this proposed rule. In June 2020, the Commission recommended that Congress provide additional federal funding to states to enhance state capacity to develop expertise in Medicare and to implement integrated care models (MACPAC 2020). MACPAC has heard from state officials that they struggle with competing priorities, limited Medicare knowledge, and limited staff capacity to develop and implement integrated care initiatives relative to their other responsibilities. States have told us they value the guidance and support they have received through CMS, particularly the one-on-one assistance received as part of the FAI demonstrations. States noted that the wide range of technical assistance available has helped them navigate the complexities of the policy environment and expanded their ability to integrate care. If the proposed rule is finalized, we expect that continued federal support will be essential to help states implement the necessary changes.

Converting MMPs to Integrated D-SNPs

We support CMS's proposal to incorporate certain MMP features into the regulations governing D-SNPs. Many of these changes are aligned with our goal of promoting integration in existing integrated products and extend important beneficiary protections. MMPs have played an important role in advancing many of the successful approaches that are included in the proposed rule, such as enrollee advisory committees.

CMS suggests that states convert their MMPs to D-SNPs if the provisions of the proposed rule related to requiring greater integration in D-SNPs are finalized. Although the proposed rule would not make this a requirement, the agency notes that it will work with the nine states participating in the capitated model demonstration during calendar year 2022 to develop a plan for converting MMPs to integrated D-SNPs. CMS does not describe a specific timeline for the transition.

We are concerned about the proposed transition for several reasons described below.

Considerations for future rulemaking

Certain aspects of integrated coverage in the MMPs may be hard to replicate in an integrated D-SNP and should be addressed through future rulemaking by the Secretary before states are required to transition. We expand on them below. In the Commission's view, these features are key to promoting integration, increasing the availability of integrated care, and increasing enrollment in integrated plans.

First, MMPs allow for states to share in savings to Medicare that may result from integration, which CMS acknowledges would be lost if MMPs were converted to D-SNPs. While CMS asked for comment on indirect approaches to shared savings in the rule, such as considering the effects of MA supplemental benefits in evaluating Medicaid capitation rates for actuarial soundness, CMS should consider additional pathways that would allow states to directly share in savings. We have heard from states that the opportunity to benefit from shared savings was an important incentive to participate in the FAI. We have also heard from states with low levels of integration that the opportunity to share in savings to Medicare could be an incentive to integrate care. MACPAC views this opportunity as an important incentive that could make integrated models available in more states.

Second, although as noted below, the proposed rule would require D-SNPs to form enrollee advisory committees, a policy feature borrowed from MMPs, they are not required to have other important mechanisms to support consumers including individualized benefit counseling and a dedicated ombudsman program. Both of these were required under the FAI and received dedicated funding. MACPAC views ombudsman programs as valuable in protecting beneficiaries in two distinct ways: educating them about their coverage and investigating and resolving their complaints.[1] Given that dually eligible beneficiaries often lack access to a single, impartial advisor to help them compare a complex set of coverage options, the Commission is concerned about the loss of these important consumer protections and the resources that support them.

Finally, unlike MMPs, D-SNPs cannot use passive enrollment. Use of passive enrollment has been a key tool for enrollment and retention in MMPs (MACPAC 2019). While states may use default enrollment to automatically enroll certain dually eligible individuals into D-SNPs, this strategy is not available to all states and may be challenging to implement, especially in states whose staff have limited Medicare expertise.[2] Default enrollment may require more state involvement than passive enrollment in the MMPs because the state would need to identify individuals eligible for default enrollment and share that information with D-SNPs. States have also told us that the upfront costs to implement these information sharing systems are considerable. We urge CMS to consider the potential burden on states of taking on new responsibilities for enrollment and to provide guidance on implementing such policies.

Smoothing the transition for states and beneficiaries

As of January 2022, over 400,000 individuals are currently being served by MMPs in nine states (ICRC 2022). If a transition plan were to go forward, some states, particularly those that have made significant investments in the MMP model, may want to allow beneficiaries currently enrolled in MMPs to transition to integrated D-SNPs gradually, so as to avoid confusion for beneficiaries and any potential disruption of services during the transition. We urge CMS to work with states to design and implement continuity of care protections to allow beneficiaries to continue seeing existing providers for a defined period of time if they must change plans and their current providers are not in the D-SNP's network. A continuity of care period is currently allowed for individuals enrolling in MMPs whose existing providers are not part of the MMP's network, if certain conditions are met. The timeline varies by state, but some states, such as California, offer a continuity of care period of up to 12 months (California DHCS 2022).

CMS should work closely with states to provide ample time and technical assistance during any transition in models. For example, states with successful and longstanding enrollee advisory committees may be interested in retaining that structure in a transition to a D-SNP. Massachusetts' One Care Implementation Council has demonstrated success in engaging beneficiaries and advocates in the operation of the demonstration (Gattine et al. 2021). CMS should consider providing federal guidance to states regarding how to transition existing advisory committee structures to D-SNPs and clarify whether federal financial support will be available to states to do so.

Unwinding the MMP model and implementing a new model could be a significant lift for states, especially for states that do not have experience contracting with fully integrated dual-eligible special needs plans (FIDE SNPs), the D-SNP product most similar to an MMP. Of the nine states with capitated MMPs, only four currently have contracts with FIDE SNPs. One state (Illinois) does not have contracts with any D-SNPs. Implementing a FIDE SNP product that provides full integration equivalent to that in an MMP may be especially challenging for these states.

Existing demonstrations are approved through 2023. CMS should consider extensions beyond 2023, if requested by states, to allow additional time to smoothly transition away from the MMP model. States report that technical assistance provided by CMS as part of the FAI was crucial to the successful implementation of MMPs, and a similar level of support will likely be needed to implement an integrated D-SNP model.

CMS should also clarify how demonstrations in Minnesota and Washington, which would not be affected by any of the proposed changes to D-SNPs, will be treated in the future.

Selected Provisions Affecting Dually Eligible Beneficiaries

Many of the policy changes in this proposed rule align with the Commission's goal of promoting greater integration. They also ensure important protections for dually eligible beneficiaries such as requiring that D-SNPs establish enrollee advisory committees. Below we have highlighted selected proposed changes and offered comments.

Refining the definitions of FIDE SNPs and HIDE SNPs

CMS proposes changing the definitions of FIDE SNPs and highly integrated dual eligible special needs plans (HIDE SNPs) (42 CFR 422.2 and 422.107) to clarify coverage options and promote integration. MACPAC is supportive of these changes because they further integration and clarify the definitions of these plans. However, states may need support to implement the new requirements and there is also some risk that fewer FIDE SNPs or HIDE SNPs will be offered under the stricter definitions. We suggest that CMS work closely with states and plans to remove barriers to offering HIDE SNPs and FIDE SNPs and make these highly integrated D-SNPs more available. The Commission highlights three specific provisions for comment:

- Starting in calendar year 2025, CMS would require all FIDE SNPs to have exclusively aligned enrollment where one entity is responsible for all Medicaid and Medicare benefits for its members. MACPAC supports moving more states toward exclusively aligned enrollment but recognizes the potential burden on states with FIDE SNPs that do not have exclusively aligned enrollment (Arizona, Pennsylvania, and Virginia). We suggest CMS work with states to ensure there is an appropriate glidepath for states to require that FIDE SNPs have exclusively aligned enrollment.
- The proposed rule would codify current CMS policy of allowing certain limited Medicaid long-term services and supports (LTSS) benefit carve-outs for FIDE SNPs. The proposed rule would also codify current policy of allowing certain limited behavioral health carve-outs for HIDE SNPs. MACPAC supports the direction CMS lays out in the proposed rule of moving toward full integration while allowing for a narrow set of benefit carve-outs. The Commission recognizes that there are significant challenges to carving in certain benefits.
- The proposed rule would require that FIDE SNP and HIDE SNP service areas align with their companion Medicaid plans. MACPAC supports this proposed change as it would make the HIDE SNP definition clearer and prevent less integrated plans from claiming this designation.

Additional opportunities for integration through MIPPA contracts

Several provisions in the proposed rule describe opportunities for states to use their contracts with D-SNPs to advance integration (42 CFR 422.107). The Commission generally supports these proposed changes and they align with prior MACPAC work highlighting how states can use authority under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) to promote integration in their contracts with D-SNPs (MACPAC 2021). However, many of these opportunities would only be available to states with exclusively aligned enrollment. We urge CMS to consider how to make these opportunities available to more states and explain whether it is feasible to do so outside of exclusively aligned enrollment. For example, of the 43 states and the District of Columbia with D-SNPs, exclusively aligned enrollment occurs in only 8 states (CMS 2019). We have heard from states that they may choose not to pursue exclusively aligned enrollment because they do not want to enroll dually eligible beneficiaries in Medicaid managed care, or they want to allow beneficiaries in fee-for-service (FFS) Medicaid and partial-benefit dually eligible beneficiaries the opportunity to enroll in D-SNPs.[3] Many more states and beneficiaries could benefit from the proposed changes if these opportunities were available to more states. The Commission highlights three specific provisions for comment:

- The proposed rule would establish a pathway for states to limit certain MA contracts to D-SNPs. Under the current policy, all of a parent company's plan benefit packages (PBPs) are under a single MA contract, which may include D-SNPs as well as other MA plans. Unless a D-SNP is the only PBP under a contract, it is not possible to get an accurate picture of the D-SNP's performance and the outcomes and experiences of dually eligible beneficiaries. The proposed rule would allow states to limit contracts to certain D-SNPs with exclusively aligned enrollment. This would allow states and CMS to evaluate aspects of plan performance, including star ratings, for D-SNPs only. However, because relatively few states require exclusively aligned enrollment, this provision would not apply to all D-SNPs in a state even though the state may be interested in better assessing the quality of all their D-SNPs, regardless

of whether they have exclusively aligned enrollment. In the Commission's view, state ability to assess quality in D-SNPs is important regardless of whether the D-SNP operates with exclusively aligned enrollment. The Commission would support extending the opportunity to limit MA contracts to D-SNPs beyond states that require exclusively aligned enrollment.

- The proposed rule would codify state ability to use contracts with D-SNPs to require integrated member materials such as an integrated summary of benefits. This proposed change only applies to D-SNPs with exclusively aligned enrollment. In the Commission's view, integrated member materials could be beneficial for all enrollees in aligned plans, regardless of whether enrollment is exclusively aligned. While it may be easier for plans with exclusively aligned enrollment to integrate member materials for all of their members, the Commission would support exploring a pathway for D-SNPs without exclusively aligned enrollment to provide integrated materials for their members. In addition, states should have the opportunity to review all D-SNP integrated materials to ensure accuracy and improve beneficiary understanding of the benefits of integration.
- The proposed rule would give states access to the CMS Health Plan Management System (HPMS) to review marketing materials as well as view models of care, member complaints, plan benefits, formulary, network, and other basic contract management information. This would allow states to view D-SNP information without requiring that D-SNPs send it separately to them and would also enable states and CMS to communicate on D-SNP performance and coordinate on program audits. However, states would only be able to view information for the small number of D-SNPs with exclusively aligned enrollment. We ask CMS to consider allowing states to view information for all D-SNPs, rather than only those with exclusively aligned enrollment. States would benefit from being able to monitor D-SNP performance and coordinate on program audits for all of their D-SNPs.

Improving beneficiary experience

MACPAC generally supports the proposed changes related to improving beneficiary experience in integrated care such as adding questions related to social determinants of health to the required health risk assessments. The Commission highlights two specific provisions for comment:

- The proposed rule would require that D-SNPs establish an enrollee advisory committee to solicit input on the beneficiary experience, similar to what exists in the MMPs. MACPAC supports this proposed change; we anticipate including a recommendation in our June 2022 report to Congress that an integrated program should include a beneficiary advisory mechanism to provide input into the integrated care program (MACPAC 2022). MACPAC would support modeling the structure of this committee after the MMP committees which include beneficiaries, families, and other caregivers. These committees should be developed by plans in partnership with advocates and should be representative of the people served by integrated programs. We look forward to future guidance on the structure and expectations of such a committee.
- A change in definition of applicable integrated plan means that the universe of D-SNPs subject to the requirement to unify appeals and grievances would expand, effective in 2023, making an integrated process available to more beneficiaries. All FIDE SNPs beginning in contract year 2025 would be subject to this requirement. The proposed rule would also extend continuation of Medicare benefits pending appeal to more beneficiaries. MACPAC supports these changes that simplify processes for

beneficiaries and providers and give more beneficiaries access to Medicare benefits pending an appeal.

Attainment of the maximum out-of-pocket limit

The proposed rule would specify that the maximum out-of-pocket limit in an MA plan is calculated based on the accrual of all Medicare cost sharing in the plan benefit, whether it is paid by the beneficiary, Medicaid, other secondary insurance or remains unpaid. This would apply even in states with lesser-of payment policies where the state may not pay the full amount of out-of-pocket costs. CMS estimates that state Medicaid agencies would save $2 billion over 10 years, increasing payments to providers by $8 billion over 10 years (CMS 2022). MACPAC supports this proposed change as it ensures that MA plans, rather than states, cover these costs.

Again, we appreciate the opportunity to provide comments on this proposed regulation.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Frank Pallone, Jr., Chair, House Energy and Commerce Committee
The Honorable Cathy McMorris Rodgers, Ranking Member, House Energy and Commerce Committee

Endnotes

[1] For example, Virginia used the state's existing long-term care (LTC) ombudsman housed within a separate state agency to establish the ombudsman for demonstration enrollees. When Virginia transitioned its integrated care program out of the FAI demonstration to a model of D-SNPs aligned with the state's managed long-term services and supports program, it retained the agreement to use the LTC ombudsman because of the value it had provided to demonstration enrollees and the state provided funding for those services (Archibald et al. 2021).

[2]Default enrollment can only be used by states that enroll dually eligible individuals and individuals likely to become dually eligible in Medicaid managed care and also where the D-SNP and Medicaid managed care parent companies are aligned. As of June 2020, only nine states are using default enrollment (MACPAC 2021).

[3] For example, certain dually eligible populations, such as American Indians and Alaskan Natives, are exempt from being required to enroll in Medicaid managed care. These statutory exemptions are intended to protect beneficiary access to providers, such as Indian Health Service providers. The exemption means beneficiaries who choose to receive their Medicaid benefits through FFS would be unable to enroll in a D-SNP if the state pursued exclusively aligned enrollment. State staff said that for states with large populations of beneficiaries exempt from Medicaid managed care, that the ability to develop an integrated model that does not require beneficiaries to enroll in Medicaid managed care is a key factor to finding a model that works for those states.

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