



January 4, 2024

VIA ELECTRONIC SUBMISSION:

<https://www.regulations.gov/>

Re: CMS-4205-P

RIN 0938-AV24

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: 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

Dear Administrator Brooks-LaSure,

The Special Needs Plan Alliance is pleased to offer our comments on this Proposed Rule. The Special Needs Plan (SNP) Alliance is a national, non-profit leadership association addressing the needs of high-risk and high-cost populations through specialized managed care. We represent 26 health plans offering over 550 plan benefit packages (PBPs) and 175 contracts through special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs). These plans have over 3 million beneficiaries enrolled across the country—totaling more than 55% of the national SNP and MMP enrollment. Our primary goals are to improve the quality of service and care outcomes for complex populations and to advance integration for those dually eligible for Medicare and Medicaid.

We greatly appreciate CMS' thoughtful work on the NPRM including the helpful scenario tables. We have framed our responses and comments on this Proposed Rule to reflect our goals and our mission to improve the lives of adults with complex needs, including those with multiple chronic conditions, behavioral and functional support needs, and those facing social risk factors.

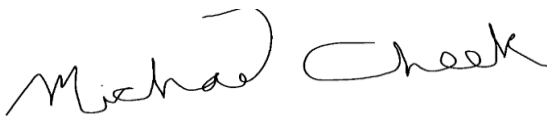
Thematically, we are particularly focusing upon:

- Working with CMS and States to identify behavioral health providers and related network challenges. Workforce and long-standing issues with accessing these providers present challenges with meeting the proposed requirements. We have made comments but also would welcome the opportunity to work with CMS on these as well as engaging the National Association of State Mental Health Program Directors (NASMHPD). We have begun a dialogue with NASMHPD and believe they could be helpful partners;

- New SSBCI Operational Requirements and Proposed Timeline. We recognize the importance of CMS understanding of SSBCI use and CMS' statutory responsibilities to have evidence of effectiveness. However, we have questions and suggestions on the proposed methodology;
- Regarding C-SNP and I-SNP proposals, we appreciate CMS' proposals. We offer comments on modifications driven by operational challenges; and
- Concerning integration, we open our discussion of this comment section with our view of the interconnected proposals aimed at increasing enrollment into integrated products as CMS discusses on page 78567. The SNP Alliance offers several framing comments in response to these four proposals to place in context our detailed, section by section comments, farther below. Below is a summary of more extensive comments:
 - The SNP Alliance requests that CMS recognize the value of all forms of SNPs in delivering integrated care. The vast majority of C-SNP and I-SNP enrollees are also dually eligible individuals;
 - We ask CMS to recognize and foster the vital role CO D-SNPs play in providing a critical starting point for state relationships on which to build integrated models (recent examples are Indiana and West Virginia). Coordination and models of care to become more obvious and more important to states;
 - The SNP Alliance has a long history of supporting enrollment of partial-benefit dually eligible individuals in D-SNPs. Demographic profiles of this population are similar to those of full benefit dual-eligibles, indicating that this group can benefit from enhanced management of chronic conditions and care coordination through SNP models of care and targeted supplemental benefits which are otherwise not available to this segment of the population under standard MA-PDs. We urge CMS to consider pathways for partial duals to participate in integrated models; and
 - On page 78575, CMS discusses what the agency views as the likely implications for its integrated focused proposals. In addition to strongly recommending CMS monitor the impacts of these proposals on beneficiaries and the stability of long-standing viable plan options, we offer an array of additional considerations.

The SNP Alliance is committed to improving the care and the lives of those most vulnerable with high-risk and high-cost needs. Our comments are intended to be constructive and solutions oriented. We would welcome the opportunity to further expand on these principles and offer recommendations.

Sincerely,



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III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Program

A. Behavioral Health (Page 78483-78486)

CMS Proposal: Beginning January 1, 2024, Medicare Advantage (MA) organizations are required to demonstrate that they meet network adequacy for four behavioral health specialty types: psychiatry, clinical psychology, clinical social work, and inpatient psychiatric facility services. Marriage and family therapists and mental health counselors will also be added to the list of provider types to meet network adequacy requirements in 2024.

CMS is proposing to amend the network adequacy standards to address the new provider types and substance use disorder (SUD) provider types through a combined behavioral health specialty type to include MFTs, MHCs, opioid treatment programs (OTPs), Community Mental Health Centers and other behavioral health and addiction medicine specialty providers (physician assistants, nurse practitioners, clinical nurse specialists, addiction medicine physicians, and outpatient mental health and substance use treatment facilities) that will enhance behavioral health access for enrollees.

SNP Alliance Response:

- The SNP Alliance agrees with the recognition and increase of additional provider types added to the list of behavioral health specialty types to increase availability and network adequacy.
- The SNP Alliance is concerned about health plans' abilities to deliver the behavioral health benefits given staffing shortages to support access to those services. According to the Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration (SAMHSA) predicted the U.S. will be short about 31,000 full-time equivalent mental health practitioners by 2025 ([National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025 \(hrsa.gov\)](https://www.hrsa.gov/2013-2025-projections)).
- The SNP Alliance supports innovative, integrated care models such as certified community behavioral health clinics (CCBHCs) which are encouraged to use telemedicine to expand access to services and alleviate workforce shortages.
- The SNP Alliance encourages the use of telehealth as a mechanism or mode for providing behavioral health services when clinically appropriate. Lessons learned from COVID-19 is that providing health care services remotely is beneficial as continuity of care is extremely valuable in the behavioral health setting.
- The SNP Alliance asks that CMS look at how geographic location impacts service area. For example, for health plans that have beneficiaries across contiguous state borders determining how the provider can operate across state lines (i.e., accreditations, licensing).
- The SNP Alliance would like CMS to consider extending the expanded telehealth credit for behavioral health, or a robust exception request process to allow plans to demonstrate when a

given geographic area may require greater reliance on telehealth providers to meet adequacy standards.

H. Update to the Multi-Language Insert Regulation (§§ 422.2267 and 423.2267) (Page 78523-78526)

CMS Proposal: CMS outlines a long history of CMS and OCR rulemaking and requirements around interpreter and translation services including the use of Multi-Language Inserts (MLI) applicable to all MA organizations and Part D sponsors as well as overlapping but conflicting requirements for MCOs under Medicaid. CMS proposes to update §§ 422.2267(e)(31) and 423.2267(e)(33) to instead require that all MA plans and Part D sponsors provide a notice of availability of language assistance services and auxiliary aids and services in the 15 most common languages in a relevant State noting this would also better align with the Medicaid translation requirements at § 438.10(d)(2).

CMS also proposes that if there are additional languages in a particular service area that meet the 5-percent service area threshold, beyond the languages described in §§ 422.2267(e)(31)(i) and 423.2267(e)(33)(i), the Notice of Availability must also be translated into those languages, as provided in current MLI requirements. This Notice of Availability would be designated as model communication material and would need to include alternative formats for individuals with disabilities.

SNP Alliance Response:

- The SNP Alliance supports CMS's updates to the current regulations that would align with Medicaid translation requirement at § 438.10(d)(2). As the number of common languages grows and changes nationally, CMS needs to be cognizant of the requirement changes occurring in programs such as Medicaid and adapt accordingly. Integrated Medicare and Medicaid plans have been experiencing this conflict between Medicaid MCO requirements and Medicare requirements regarding MLI for many years, the SNP Alliance is happy to see this proposed change.
- Likewise, the SNP Alliance supports the changes made should CMS align with OCR's final rule.

I. Expanding Permissible Data Use and Data Disclosure for MA Encounter Data (§ 422.310) (Page 78526-78531)

CMS Proposal: CMS is proposing to allow MA encounter data to be used to support the Medicaid program for certain purposes already specified for use to support the Medicare program in § 422.310(f)(1)(vi) and (vii). CMS wants to add a new subsection § 422.310(f)(3)(v) to allow for MA encounter data to be released to States Medicaid agencies in advance of the completion of risk adjustment reconciliation for the specific purpose of care coordination for individuals who are dually eligible, when CMS determines that releasing the data to a State Medicaid agency before reconciliation is necessary and appropriate to support activities and uses authorized under paragraph (f)(1)(vii). Additionally, CMS proposes to add "and Medicaid program" to the current MA encounter data use purposes codified at § 422.310(f)(1)(vi) and (vii). This language would enable CMS to use the data and

release it for the purposes of evaluation, analysis, and program administration for Medicare, Medicaid, or Medicare and Medicaid combined purposes. CMS's proposed changes would begin January 1, 2025.

SNP Alliance Response:

- The SNP Alliance supports sharing MA encounter data with states to aid in integrating care for people who are dual eligible beneficiaries. The SNP Alliance and its members note the usefulness of technical assistance to States on using encounter data effectively would be welcome. These data can assist in care coordination and integration of care across Medicare and Medicaid programs if properly used and in a timely way. This has the potential for improving measurement alignment, performance evaluation, and supporting quality initiatives for dual eligible individuals.
 - *CMS Guidance Around Processes* - The SNP Alliance suggests that CMS provide suggested timelines and processes to States to encourage consistency and effective operational best practices around these data (content and limitations of the data set, processes, and timelines for obtaining, disclosure parameters and suggested uses for these data and where/for what purposes it should not be used)
 - *Notification* - SNP Alliance recommends providing plans with notification when MA encounter data is shared with the State.
 - *Feedback Loop-Two-Way Communication* - SNP Alliance recommends that CMS provide guidance to States on a feedback loop with two-way communication between the State and the plan, particularly when the State is analyzing and interpreting these data, and a process to assist in addressing data anomalies and in interpretation for effective use. This is particularly important regarding performance evaluation and quality reporting.
 - *Greater Measurement Alignment* - We hope that an outcome of this data sharing will be greater alignment across Medicare and Medicaid of quality measures and performance evaluation for dual eligible individuals with some ability to tailor or customize from the core set of measures to a meaningful set which reflect the characteristics of sub-groups of individuals (e.g. younger people with physical disabilities, frail elderly, individuals with complex chronic illnesses, etc.) found within the diverse group of individuals who are dually eligible.
 - *Analyze and Publish Report* - We recommend that CMS and the States work together to produce a report following two years of implementation that provides the industry with information on how the sharing of Medicare encounter data has facilitated greater coordination, integration, and quality measure alignment.

J. Standardize the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Appeals Process (Page 78531-78534)

CMS Proposal: CMS is proposing that Medicare Advantage (MA) organizations must exhaust all levels of appeal for medical record review determinations before the payment error calculation appeals process can begin, because RADV payment error calculations are directly based upon the outcomes of medical record review determinations.

Contract-level RADV audits are CMS’s main corrective action for overpayments made to MA organizations when there is a lack of documentation in the medical record to support the diagnoses reported for risk adjustment.

SNP Alliance Response:

- The SNP Alliance supports CMS’s efforts to address gaps and operational constraints included in existing RADV appeal regulations that would standardize and simplify the RADV appeals process for CMS and MA organizations.

IV. Benefits for Medicare Advantage and Medicare Prescription Drug Benefit Programs

B. Evidence as to Whether a Special Supplemental Benefit for the Chronically Ill (SSBCI) Has a Reasonable Expectation of Improving the Health or Overall Function of an Enrollee (42 CFR 422.102(f)(3)(iii) and (iv) and (f)(4)) (Pages 78534-78539)

CMS Proposal: Supplemental benefits, including SSBCI, are generally funded using MA plan rebate dollars. In contract year 2023, 478 MA plans are offering this as an SSBCI. CMS is proposing to update processes for reviewing and approving SSBCI to manage the growth and development of new SSBCI offerings, as well as to ensure compliance with the statutory requirements at section 1852(a)(3)(D). Specifically, CMS proposes to:

- Require redesignated § 422.102(f)(4)(iii) that an MA plan apply and document its written policies and criteria that it establishes for determining whether an enrollee is eligible to receive an SSBCI.
- Redesignate what is currently § 422.102(f)(3) to § 422.102(f)(4), and new § 422.102(f)(3), new requirements for each MA plan that includes an item or service as SSBCI in its bid. Requirements include:
 - relevant acceptable evidence (Pages 78536-78538 definition)
 - a bibliography of all “relevant acceptable evidence” (Pages 78536-78538 definition)

CMS seeks comments on:

- Bibliography - Proposed requirement that an MA organization that includes an item or service as SSBCI in its bid must, by the date on which it submits its bid to CMS, establish in writing a bibliography of all relevant acceptable evidence concerning the impact that the item or service has on the health or overall function of its recipient.
- Definition - of “relevant acceptable evidence,” including the specific parameters or features of studies or other resources that would be most appropriate to include in our definition.
- Citation - each citation in the written bibliography, the MA organization would be required to include a working hyperlink to or a document containing the entire source cited.
- Application - apply this requirement to all items or services offered as SSBCI, or whether there are certain types or categories of SSBCI for which this requirement should not apply.

- Should CMS permit changes in SSBCI eligibility policies during the coverage year, and, if so, the limitations or flexibilities that CMS should implement that would still allow CMS to provide effective oversight over SSBCI offerings. The ability to change plan rules during the year does not permit changes in benefit coverage but would include policies like utilization management requirements, evidentiary standards for a specific enrollee to be determined eligible for a particular SSBCI, or the specific objective criteria used by a plan as part of SSBCI eligibility determinations.
- Document Ineligibility - proposal to require an MA plan to document its findings that a chronically ill enrollee is ineligible, rather than eligible, for an SSBCI.

SNP Alliance Response:

- The SNP Alliance supports CMS in ensuring that SSBCI and other supplemental benefits are consistent with applicable law. We appreciate the intent to have clear eligibility criteria, utilization tracking, and other data around use of SSBCI. Recognizing these goals and issues of feasibility and accuracy, we have additional comments and suggestions:
 - *CMS Maintain a Repository or Master List of Evidence on Benefits* – the SNP Alliance suggests that CMS serve as the repository of evidence for use by all plans. Rather than having every health plan create a similar bibliography, it would be far more efficient to have one list maintained at the national level that is updated periodically.
 - *Use of Existing Lists Prepared by an Agency in the Federal Government* - In addition, the SNP Alliance recommends that the list of evidence-based programs that have been reviewed, vetted, and verified by a federal agency, such as the Administration for Community Living (ACL) be provided or referenced. For example, ACL has contracted with the National Council on Aging for many years to convene a panel of scientists and researchers who review programs and make recommendations to ACL for those that meet a standard set of criteria for being considered “evidence-based” to be on a publicly available site. See: <https://www.ncoa.org/evidence-based-programs> While this list is not exhaustive it is an existing structured and comprehensive list of nearly 80 programs that met the ACL criteria as evidence-based
 - *Unique Benefits or Services* - When plans select benefits to offer that are not on the CMS or ACL (or comparable) list, then the plan could be asked to create a bibliography of the evidence supporting the decision to offer the service. We also recommend that CMS provide criteria for what is considered sufficient evidence.
 - *SSBCI Eligibility for People with Progressive Disease or Disability* An area where we believe additional guidance may be needed is in defining the scope of who is eligible to receive SSBCI and whether certain individuals are excluded due to their disease course or level of disability. For example, if a benefit of in-home support is offered to a person who, because of the progressive nature of their disease or condition (e.g., ALS, Parkinson’s advanced dementia, etc.) –the service will not maintain or improve the individual’s health or function. It will help that person cope with progressive decline. We do not believe that CMS is suggesting these individuals cannot receive SSBCI services. We ask for clarification in definition and any restrictions around serving these individuals. There is court precedent. For example, *Jimmo v. Sebelius* challenged the “improvement standard” in Medicare specific to therapy.
 - *Definitions & Criteria* – How much of an “impact that the item or service has on the health or overall function of its recipient” must be demonstrated for evidence to be accepted? Can

- CMS define this? How many enrollees must use the benefit for the evidence of impact to be considered valid/ statistically significant?
- *Effect of Confounding Variables* - How will CMS ensure that evidence of impact of an SSBCI benefit is not skewed by the invisible/ undocumented impact of another intervention (care coordination, or non-covered social supports, or differences in underlying population - e.g., higher income Medicare Advantage enrollees vs. dual eligible beneficiaries)?
 - *Acceptance of Internal Evaluation* - The SNP Alliance appreciates CMS' recognition that while many service benefits such as housing modifications, in-home supportive services, and other services provided through SSBCI pathways have some level of peer-reviewed and published evidence to support the connection between the intervention or program offering and expected outcomes around health or function, others have less robust evidence. Therefore, we appreciate that CMS will accept internal evaluation linking the service to expected outcomes for defined beneficiaries but would recommend that CMS define the way or method they will analyze/assess internal plan evaluation data. Additionally, we ask CMS to accept evidence for SSBCIs that is not specific to the Medicare population. Many special needs plan enrollees are under 65 with different needs and capabilities, and organizations like the Commonwealth Fund (see: [Guide to Evidence for Health-Related Social Needs Interventions: 2022 Update \(commonwealthfund.org\)](https://www.commonwealthfund.org/publications/research-on-sdo-h-interventions-2022-update)) publishes research on SDOH interventions that align with many of the SSBCIs offered in MA plans).
 - *Research on Ethnically or Culturally Diverse Individuals* - Another area where evidence within published research is scant is in scientific studies showing how a particular intervention or service can be adapted or used by/with specific ethnic, racial, and non-English-speaking populations. There is less published research on effective evidence-based “proven” programs—as most studies’ subjects are White and English-speaking. Therefore, it would be especially important and useful for CMS to maintain a library of evidence on emerging benefits or use with complex, diverse, and non-English speaking populations. This is especially important for benefits targeted at a specific population that are not well researched.
 - *Impact on Bid Review* - CMS bid reviewers will likely face a much more complex bid review process using this standard of requiring evidence of SSBCI benefits in special populations. CMS publishing criteria used to determine acceptance/denial of a bid based on SSBCI evidence would help MAOs minimize overwhelming the bid review process with denials/ response to denials. A related question is: Will CMS provide longer turnaround times for MAOs to respond to desk review objections to SSBCI evidence submitted?

C. Mid-Year Notice of Unused Supplemental Benefits (§§ 422.111(l) and 422.2267(e)(42) (Pages 78539-78540)

CMS Proposal: CMS remains concerned that utilization of these benefits is low even though the number of supplemental benefit offerings has risen significantly in recent years. CMS wants to establish standards, implement a disclosure requirement, and provide a model notification to enrollees of supplemental benefits they have not yet accessed through new provisions at §§ 422.111(l) and 422.2267(e)(42) to establish this new disclosure requirement and the details of the required notice, respectively.

SNP Alliance Response:

- The SNP Alliance appreciates the intent of this proposal but recommends re-working the proposal to focus on request for an aggregate report from the plan at 6 months of use of SSBCI benefits as compared to the anticipated volume of service use expressed in the plan bid. This is to address the challenges in a 6-month notification as proposed. Specifically, the challenges include:
 - *Criteria or appropriateness of these Benefits will often be Nuanced* – The appropriateness or relevancy of these SSBCI to the population is unlike other benefits, which are relevant for many people (e.g., dental, vision). Rather these SSBCI are often specialized for specific conditions or situations and would have additional criteria for appropriateness. That is, each service/benefit may be tailored to a small subset of enrollees and pertain to specific circumstances or pre-conditions or have contraindications. For example, pest control services would be relevant only to enrollees who live in a dwelling and are experiencing insect or rodent infestation. An animatronic cat designed for people with dementia may not be suitable for or acceptable to some individuals—others dislike or react negatively to this robotic “pet” (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8082946/>). Caregiver support is relevant to those enrollees who have a family or friend informal caregiver who is interested in receiving help.
 - *Capturing change in condition or eligibility* – Diagnoses or circumstances for enrollees may change during the year (not just the beginning of the year), making the proposal difficult to achieve and provide real time information midway through the year.
 - *Lack of Engagement by the Enrollee* – Another issue is the lack of engagement from enrollees. They may not know about the offered service or when to accept/sign off on receiving the service, or what happens if they do not utilize a service within a given time frame. The mid-year notice could risk inaccurate information going out to enrollees.
 - *Feasibility to Operationalize* – the SNP Alliance appreciates CMS’ need to understand benefit use. However, we are considering the feasibility challenges ahead to find/track every person who was eligible for each benefit, was offered the benefit, and then used or refused the benefit. Knowing who was an acceptable candidate, was offered the benefit, and then refused would be very difficult—probably requiring manual review of care manager notes. Then, being able to aggregate that information to see who is “missing” would require another review of the remaining members’ situations to determine why they may have not been good candidates or if they simply did not know about the benefit. Finding these individuals who could have benefited and have not yet used the benefit to inform them of its availability—would be a substantial undertaking. The SNP Alliance is concerned that operationalizing this proposal will lead to plans moving away from person-centered benefits which is a crucial aspect of special needs plans (ATI). The SNP Alliance would welcome the opportunity to work with CMS on developing an efficient method that provides CMS meaningful information.
 - *Data Lags* - Unlike providers who offer medical or behavioral health services defined under Medicare Part A or B benefit definitions, there may not be an electronic data platform for the service provider to submit timely information to the health plan—therefore the data would have gaps given lags in claims. Given up to 90-day claims lags, as much as half of the services provided could be missing in a mid-year notification at 6 months. As CMS implements Supplemental Benefit Utilization and Costs to the Part C Reporting Requirement in 2024, the SNP Alliance asks CMS for status updates on the regular monitoring of

supplemental benefit utilization. Likewise, we will poll our membership about their experiences with this new reporting requirement to provide feedback to CMS.

Based on feedback from our membership, the SNP Alliance suggests CMS consider other avenues through which to communicate supplemental benefit availability to enrollees utilizing existing touch points and outreach efforts that the plan has with an enrollee.

D. Annual Health Equity Analysis of Utilization Management Policies and Procedure (Page 78540)

CMS Proposal: CMS proposes to add new requirements for an annual Utilization Management review of the use of prior authorization and its impact on enrollees with LIS/DE or Disability as proxies for social risk factors. Specially, CMS proposes new actions by the Utilization Management Committee:

1. § 422.137(c)(5) – UM Committee must have at least one member with health equity expertise as demonstrated through educational degrees, credentials, or experience
2. § 422.137(d)(6) -UM Committee must conduct annual health equity analysis of the use of prior authorization and HE expert must approve the final report of the analysis before it is posted
3. Prior Authorization impact on enrollees with LIS/DE, or Disability as social risk factors
4. Propose eight specific analysis metrics in detail.
5. § 422.137(d)(7) that by July 1, 2025, and annually thereafter, the health equity analysis must be posted on the plan's publicly available website in a prominent manner

SNP Alliance Response:

- The SNP Alliance appreciates this focus on persons who are DE/LIS or disabled. We offer the following suggestions and have requests for clarification:
 - *UM HE Expertise* - The SNP Alliance would like CMS to clarify the expectations of the UM health equity expert. In many health plans, the current health equity expert is not one single person but an array of people with expertise, certificates, and credentials.
 - *Proportion of Enrollees for Review* - The SNP Alliance appreciates the intent for an annual UM review and the detail on metrics for an annual analysis but suggests that it will be very important to first understand the proportion of the plan's enrollment in terms of the LIS/DE/Disabled population and R/E/L characteristics when conducting the analysis. In other words, if the entire enrolled population is LIS/DE/Disabled, the UM Committee will be reviewing all prior authorizations.
 - *Importance of Contextual Information* -In addition, the SNP Alliance suggests that CMS consider guidance about the importance of contextual information about the individuals that might indicate service need profile and why certain services/use was not advisable based on clinical guidelines – such as person in hospice, contraindicated by the person's physician (e.g., surgical procedure) due to frailty or other medical issues, or to categorize when the service was offered but the person refused. Recognizing that

cultural norms are so different from what standardized Medicare policy would say you should cover and impact utilization of services.

- *Enrolled for Full Calendar Year* - Suggest focus for the UM Committee should be for individuals enrolled for a full calendar year.
- *Comparisons, Benchmarks* - Would appreciate CMS' guidance on comparison groups for high DE/Disabled/LIS populations to provide relevant benchmarks.
- *First Year of Learning, with Full Implementation in 2026* - The SNP Alliance requests that CMS set the first year (2025) as a learning year and opportunity to improve the information for readiness for the public. This would extend the public posting to the health plan's website until July 1, 2026.
- The SNP Alliance requests additional information about how to ensure that the information can be readily understood by the lay public prior to the UM report public website posting.

IV. Enrollment and Appeal

A. Revise Initial Coverage Election Period (ICEP) Timeframe to Coordinate with A/B Enrollment (§ 422.62 (Page 78542-78544))

CMS Proposal: CMS is proposing to revise the end date for the ICEP for those who cannot use their ICEP during their Initial Election Period (IEP). CMS proposes in § 422.62(a)(1)(i) that an individual would have 2 months after the month in which they are first entitled to Part A and enrolled in Part B to use their ICEP. Under proposed § 422.62(a)(1)(i), the individual's ICEP would begin 3 months prior to the month the individual is first entitled to Part A and enrolled in Part B and would end on the last day of the second month after the month in which the individual is first entitled to Part A and enrolled in Part B.

By extending the time frame for the ICEP under § 422.62(a)(1)(i), CMS believes beneficiaries that are new to Medicare will have additional time to decide if they want to receive their coverage through an MA plan.

SNP Alliance Response:

- The SNP Alliance supports CMS's intention to extend the enrollment period for beneficiaries' initial coverage in Medicare.
- The SNP Alliance supports policies and practices that make it easier for all beneficiaries to enroll in and retain coverage, understand their coverage options, and select appropriate coverage.
- The SNP Alliance supports this proposal as it would not result in a new or additional paperwork burden since MA organizations are currently assessing applicants' eligibility for election periods as part of existing enrollment processes.

B. Enhance Enrollees' Right to Appeal an MA Plan's Decision to Terminate Coverage for Non-Hospital Provider Services (§ 422.626) (Page 78544)

CMS Proposal: To modify the existing regulations regarding fast-track appeals for enrollees when they untimely request an appeal to the QIO, or still wish to appeal after they end services on or before the

planned termination date. The proposed changes would bring the MA program further into alignment with Original Medicare regulations and procedures for the parallel process. Specific requirements: a) QIO, rather than MA plan, to review untimely fast-track appeal of an MA Plan's decision to terminate non-hospital services; and b) allow enrollees to appeal the decision to terminate services after leaving an SNF or otherwise ending coverage before the planned coverage date.

SNP Alliance Response:

- Post-Acute Care (PAC) services are important to ensure full recovery to function and prevent rehospitalization, an important quality metric for SNPs – the SNP Alliance supports changes in processes which enhance needed PAC services.
- Medicare beneficiaries have varying windows of time to use PAC benefits following hospital discharge, for SNF, 30 days for example. To reduce beneficiary confusion, the SNP Alliance concurs with CMS' steps to align MA policy regarding accessing PAC services with Original Medicare.
- Regarding QIO processing, we are aware of workforce and workload challenges within QIOs. While we do not oppose transitioning fast-track to QIOs, we recommend CMS assess QIO capacity on a region-by-region basis before transitioning the responsibilities. If QIOs do not have the needed resources, CMS' policy goal(s) would not be achieved and, in fact, could exacerbate the problem.
- Finally, there is considerable confusion among PAC providers and beneficiaries regarding which entities are making coverage decisions. For example, PAC Benefit Managers often are added to PAC providers' contracts after contracts are signed with no or nominal provider education and similar issues with beneficiary communication. We recommend CMS produce PAC provider educational materials in MLN Matters Articles - Provider Education, Medicare Provider Manual updates, and PAC Open Door Forums. Further, recommend requesting Medicare beneficiary advocacy group input on changes to the NOMNC language and inclusion of the Administration for Community Living, National LTC Ombudsman Office in the updates.

VI. Medicare Advantage/Part C and Part D Prescription Drug Plan Marketing and Communication

A. Marketing and Communications Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.2267) (Page 78549-78551)

CMS Proposal: The SSBCI program is targeted to Medicare beneficiaries with an eligible chronic or functional condition from a list of devised by CMS. The January 2021 Final Rule established a new requirement for a disclaimer to be used when SSBCI are mentioned. However, there have been extensive complaints about this disclaimer. In this proposal CMS is clarifying the SSBCI program language and requirement within the disclosure.

The proposed disclaimer insists that that MA organizations offering an SSBCI on a MA plan must include the SSBCI disclaimer in all marketing and communication materials. On the disclaimer, MA organizations must list the chronic or functional condition the enrollee must have in order to be eligible for the SSBCI

offered by the MA organization and list the eligibility requirements the enrollee must meet in addition to having an eligible chronic condition.

SNP Alliance Response:

- The SNP Alliance supports CMS’s efforts to set parameters around marketing and communication of SSBCI, and specifically to improve clarity around SSBCI eligibility with a consistent disclaimer.
- A challenge will be to either to create a universal disclaimer that can be used for all SSBCI services, or to craft a simple language disclaimer that is easily understood but is tailored to a specific service.
 - For example, a universal disclaimer could be:

“This benefit is for individuals who meet the federal definition of ‘chronically ill’ and where there is a reasonable expectation of improving or maintaining health or function.”

Then, the tailored disclaimer would be added onto that statement, for example, for food/meals:

“This benefit is for individuals who meet the federal definition of ‘chronically ill’ and where there is a reasonable expectation of improving or maintaining health or function, and who have indicated they are food insecure through answering a screening question.”

- We encourage CMS to provide guidance for a universal statement and on how to tailor specific additional disclaimers, for example: “Must be confirmed by your case manager as being eligible.” “A case manager must arrange for services once an individual has demonstrated they meet the criteria.” Or “Screening is required to access this benefit.”

B. Agent Broker Compensation (Pages 78551-78556)

CMS Proposal: Agents and brokers help millions of Medicare beneficiaries to learn about and enroll in Medicare, MA plans, and PDPs. These entities are paid to enroll beneficiaries in plans. The compensation structure for enrolling beneficiaries has started to exceed the maximum compensation allowed under the current regulations. CMS propose to tighten agent-broker compensation in four areas:

1. *Limitation on Contract Terms* (Page 78554)—beginning in contract year 2025, MA organizations must ensure that no provision of a contract with an agent, broker, or TPMO has the direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent’s or broker’s ability to objectively assess and recommend which plan best meets the health care needs of a beneficiary.
2. *Compensation Rates* (Pages 78554-78555)—CMS is proposing to amend regulations to require that all payments to agents or brokers that are tied to enrollment, related to an enrollment in an MA plan or product, or are for services conducted as part of the relationship associated with the enrollment into an MA plan or product must be included under compensation. CMS is proposing to change the caps on compensation payments that are currently provided to set rates that would be paid by all plans across the board.
3. *Administrative Payments* (Pages 78555-78556)—CMS proposes that beginning in 2025, fair market value (FMV) will be increased by \$31 to account for administrative payments included under the compensation rate and will be updated annually in compliance with the requirements for FMV updates. Many plans are paying agents and brokers for conducting health risk assessments (HRAs) and categorize these HRAs as an “administrative service” upwards of \$125 per completed HRA. CMS also considered an alternative policy, wherein the

definitions of compensation and administrative payments would remain the same, but the option for a plan to make administrative payments based on enrollment would be removed and instead these payments would need to be made a maximum of one time per administrative cost, per agent or broker.

4. *Agent Broker Compensation for Part D Plans* (Page 78556)—CMS proposes applying the same compensation rules to the sale of both MA plans and PDPs to ensure that both plan types are being held to the same standards and are on a ‘level playing field’ when it comes to incentives faced by agents and brokers, including the FMV compensation payment increase.

SNP Alliance Response:

- The SNP Alliance supports CMS’s efforts to address agent-broker compensation. We agree with the Administration and CMS that broker-agent compensation and tactics for enrollment have become increasingly competitive and, at times, plan selection has not been in the best interest of the beneficiary or enrollee.
- Regarding limiting contract terms, the SNP Alliance encourages CMS efforts to protect beneficiaries from enrolling in MA plans that are not suited for their health care needs. The SNP Alliance does ask for clarification on how CMS plans to enforce this proposed regulation regarding limiting contract terms.
- The SNP Alliance applauds CMS in endeavors to curb compensation rates among agents and brokers. In recent years, the media, Congress, and our members have reiterated complaints about the agent-broker sales approach hitting targets and quotas to meet incentives over plan enrollment. However, the SNP Alliance wants to express concerns about viability of the single state and regional plans who use the compensation rates to compete with larger, national plans within a given service area. There is a concern that this will reduce the ability of these smaller plans to compete.
- Regarding administrative payments pertaining to health risk assessments (HRAs) we have heard from our members that utilizing agents/brokers is sometimes necessary to meet regulatory requirements to ensure 100% of individuals enrolled have an HRA complete within 90 days of enrollment. Generally, the agent/broker obtains basic information from prospective members such as race, ethnicity, and preferred/primary language. This information is critical to contacting the person after enrollment and setting up their profile for outreach and care management. Once a person is enrolled, the plans conduct care management and clinical review with a more comprehensive HRA and verify the initial information.
- The SNP Alliance agrees with CMS and supports applying the same compensation rules to the sale of both MA plans and PDPs. We want both plan types are being held to the same standards and to be on a ‘level playing field’ when it comes to incentives faced by agents and brokers.

VII. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

B. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184) (Pages 78557-78559)

CMS Proposal: In this rule, CMS is proposing a measure change to the Star Ratings program and an updated methodology for calculating scaled reductions of the Part C appeals measures for performance periods beginning on or after January 1, 2025, unless noted otherwise. CMS indicates interest in measure alignment across Medicare and Medicaid. CMS has submitted the Initiation and Engagement of Substance Use Disorder Treatment (IET) measure (Part C) (a Universal Foundation measure) to the 2023 Measures Under Consideration (MUC) list process for review by the Measures Application Partnership (MAP) prior to proposing use of that measure in the Star Ratings system through future rulemaking to align with the Universal Foundation.

SNP Alliance Response:

- The SNP Alliance appreciates CMS' work to help define a core measure set and align across Medicare and Medicaid. The measures chosen should have utility/be relevant for all Medicare members, when possible. We support the progress toward a Universal Foundation set.

C. Data Integrity (§§ 422.164(g) and 423.184(g)) (Pages 78559-78561)

CMS Proposal: CMS is proposing to use data from MA organizations, the Independent Review Entity (IRE), or CMS administrative sources to determine the completeness of the data at the IRE for the Part C appeals measures (Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions) starting with the 2025 measurement year and the 2027 Star Ratings.

SNP Alliance Response:

- The SNP Alliance is concerned the smaller plans will be more affected by this proposed review given the target of 95% accuracy.

F. Health Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3)) (Page 78562)

CMS Proposal: The methodology for Health Equity Index (HEI) is already codified. This pertains to contract consolidation. For the first year following a consolidation, CMS will assign the surviving contract the enrollment-weighted mean of the HEI reward using enrollment from July of the most recent measurement year. For the second year, CMS proposes new paragraphs at §§ 422.166(f)(3)(viii)(B) and 423.186(f)(3)(viii)(B) that, when calculating the HEI score for the surviving contract, the patient-level data used in calculating the HEI score would be combined across the contracts in the consolidation prior to calculating the HEI score.

SNP Alliance Response:

- The SNP Alliance appreciates the intent of the HEI as supporting plans that serve a high proportion of LIS/DE/Disabled by recognizing performance. The proposed contract consolidation policy seems consistent with other CMS policies.
- We request additional information from CMS on the Health Equity Index. Specifically, we ask the CMS to clarify, analyze, and report on the following:

1. *Measures* - Clarify what measures will be used in MY2024 toward creating the HEI composite measure and to publish this measure list and the measure list for MY2025 as soon as possible.
2. *Update Model* - The SNP Alliance asks CMS to update the HEI modeling using more current data than was previously used, as the prior model included experience from before/during the pandemic. Please publish the results as soon as possible.
3. *Review Impact* – The SNP Alliance requests that CMS review the effect of the HEI median threshold on PBPs within plans that have a high proportion of DE/LIS/disabled but are within a consolidated H# contract, as we understand this provision could prohibit their access to the HEI. It would be helpful to see the number of beneficiaries who are dual eligible, disabled, and low-income status people who are enrolled in these plans that would not meet the threshold of being eligible for the HEI.
4. *Provide Technical Guidance to Determine Net Effect*
 - We also CMS to provide additional guidance and technical assistance to plans trying to model the net effects of all of the Star methodology changes that have been or will be shortly occurring—including elimination of the reward factor, addition of the HEI (to approximately one-third of plans that meet the median threshold will be able to access that reward factor), the Tukey method changes, and application of guardrails. We recognize that CMS would have to use existing data to conduct this net effect analysis and that it would be a retrospective analysis using the most recent data, but this would be much appreciated as earlier modeling used older data. Any guidance on how plans can plan/evaluate the effects of these changes on their own will be very welcome.
 - The SNP Alliance requests that CMS conduct analysis on the net effect of high DE/LIS/Disabled plans that will be impacted negatively by the removal of the existing reward factor—although they may access the HEI. Will this be a null effect or does CMS anticipate greater reward to these plans as a result of the HEI replacing the existing reward factor? We would appreciate seeing this analysis.

VIII. Improvements for Special Needs Plans

A. Verification of Eligibility for C-SNPs (§ 422.52(f)) (Pages 78562-78564)

CMS Proposal: CMS is looking to codify guidance on the steps MA plans must take to verify conditions for enrollment in a chronic condition SNP (C-SNP). C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined at § 422.2.

Confirmation from the individual applicant's current physician is required to confirm that the enrollee has the specific severe or disabling chronic condition(s) new § 422.52(f)(1) or conditions in the case of an individual seeking enrollment in a multi-condition C-SNP new § 422.52(f)(1)(i).

SNP Alliance Response:

- The SNP Alliance supports the verification of eligibility for C-SNP enrollment, but we are concerned about the language in the proposal “physician.” We feel as though “physician” could be too limiting. In today's care settings, nurse practitioners and physicians' assistants are beneficiary's primary care

providers not physicians. By limiting the language to “physician” only, there is the possibility of increasing burden on physician.

- The SNP Alliance suggests expanding the language to include provider.
- The SNP Alliance would like to express concern to CMS that “current” physician could be too limiting and increase provider burden.

B. I-SNP Network Adequacy (Page 78564-78566)

CMS Proposal: CMS proposes to adopt a new exception for facility based I-SNP plans (not Institutional Equivalent) from the network evaluation requirements. These exceptions apply if a facility based I-SNP is the only plan type under a contract, because network adequacy is determined at the contract level. The two exceptions are:

- The first proposed new basis for exception is if the I-SNP is unable to contract with certain specialty types because of the way enrollees in I-SNP receive care. Proposing I-SNP submit evidence that providers are unwilling to contract because of the way enrollees receive care through model of care.
- Second exception basis is for facility based I-SNPs that provides sufficient and adequate access through additional telehealth benefits, for the required specialties in place of in person providers and coverage is provided for out-of-network services in person when requested by an enrollee.

SNP Alliance Response:

The SNP Alliance is thrilled CMS finally recognizing I-SNP network adequacy requirements. However, we have concerns about the exceptions, rationale, and type of evidence to be considered in this proposal.

- The SNP Alliance would like more clarification on the requirement that the plan contracts have only facility based I-SNPs. Our members have concerns about the process for moving contracts if other products on current on the same contract and questions about the about the financial, clinical, and quality ramifications of having a separate contract number for facility based I-SNPs.
- We ask that CMS consider updating the review process for exceptions, specifically that plans be given an opportunity to receive the exceptions review prior to the timeline where plans need to determine if they will withdraw their service area expansion.
- The SNP Alliance wishes for CMS to expound on evidence that facility based I-SNPs must obtain from providers that are unwilling to contract because of the way enrollees receive care through model of care. Providers are not likely to respond to ongoing outreach requests for contracting. Making it difficult to get any written/email response and unlikely that plan seeking exceptions would be able to receive either attestations or written confirmation from the providers confirming their lack of interest to contract with the plan, let along getting a written response may not have exact wording to indicate “model of care” is the reason for non-contracting.
- We would ask that CMS consider rather than provider attestation, that CMS consider allowing plans to attest to their contracting efforts with providers. As part of exception attestation process, plans could submit and maintain documentation that demonstrates multiple methods and attempts of contracting outreach to providers (e.g., letter, email, phone).

C. Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization (§§ 422.503, 422.504, 422.514, 422.530, and 423.38) (Page 78566-78575)

Introduction and Background

On page 78567, CMS discusses its four interconnected proposals aimed at increasing enrollment into integrated products. The SNP Alliance offers several framing comments in response to these four proposals to place in context our detailed, section by section comments, farther below.

SNP Alliance Comments:

- The SNP Alliance requests that CMS recognize the value of all forms of SNPs in delivering integrated care. The vast majority of C-SNP and I-SNP enrollees are also dual eligible individuals. We strongly recommend CMS explore C-SNP and I-SNP roles in integration. We have formed I and C-SNP Work Groups and will be producing policy ideas associated with such approaches. We would welcome a discussion on this topic with CMS.
- We ask CMS to recognize and foster the vital role CO D-SNPs play in providing a critical starting point for state relationships on which to build integrated models (recent examples are Indiana and West Virginia). Since states have already approved operation of D-SNPs, a beginning point for this relationship already exists. And as more researchers, states and policy makers understand how poorly managed chronic conditions are driving unsustainable costs of care for a growing aging population, we expect the value of CO-D-SNP care coordination and models of care to become more obvious and more important to states.
- In addition, the SNP Alliance has a long history of supporting enrollment of partial-benefit dual eligible individuals in D-SNPs. Demographic profiles of this population are similar to those of full benefit dual-eligibles, indicating that this group can benefit from enhanced management of chronic conditions and care coordination through SNP models of care and targeted supplemental benefits which are otherwise not available to this segment of the population under standard MA-PDs. We appreciate CMS mention of the opportunity for CO-DSNPs to serve partial-benefit dual eligible individuals in these rule provisions. We ask CMS to further recognize the role CO-DSNPs can play through models of care and targeted supplemental benefits designed to focus on better clinical management of chronic conditions to slow the trajectories of care into need for Medicaid services by encouraging states to include this population in state MIPPA contract eligibility parameters and allowing separate PBPs to facilitate their enrollment. As CMS adopts enrollment incentives and other mechanisms to increase enrollment in integrated care programs, CMS should consider options for encouraging enrollment of partial benefit dual individuals in CO D-SNPs through targeted cross walks and other mechanisms. This approach also allows for continuity of care at the point which a partial benefit dual individuals becomes fully dual eligible.
- On page 78575, CMS discusses what the agency views as the likely implications for its integrated focused proposals. In addition to strongly recommending CMS monitor the impacts of these

proposals on beneficiaries and the stability of long-standing viable plan options, we offer the following additional considerations:

- CMS indicates that the continuous monthly integrated care special enrollment period (SEP) will provide increased integrated plan enrollment and is intended to offset potential loss of MA-PDs in the Medicaid Market in terms of parent company behavior. In addition, since it only applies to integrated programs, the new SEP will not extend to dual eligible people in states without a path to HIDE or FIDE and in non-Medicaid-managed care states. CMS needs to monitor whether this policy is working as intended.
- CMS use of direct federal authority to facilitate aligned enrollment will have varying impacts on states based upon their integration status. We recommend CMS assess state capacity to move forward with new federal requirements and work closely with them to reduce confusion among states and plans during implementation. Specifically, in our comments we note concerns about the need for more detail on what mechanisms will be used for facilitating enrollment changes necessary to achieve the intended aligned enrollment and whether they are driven by Medicaid enrollment or D-SNP enrollment choices.
- We believe the integration proposals will have varying results on Medicaid contracts with states. There may be differing impacts on types of plans (small, large, provider led, tenure with states) depending on whether the markets and procurements drive more competition for Medicaid contracts or drive less competition for Medicaid contracts because it is easier to be a CO-DSNP in a state that allows CO-DSNPs.
- We suggest CMS assess whether the quality of plans with State Medicaid Agency Contracts (SMACs) is being positively or negatively impacted by these policies. For example, for ease of compliance, some states may favor plans with which they have existing relationships when in Medicaid procurements. Alternatively, larger plans may have more capacity to respond to a State Medicaid MCO RFP and submit its MA bid relative to small plan capacity. CMS should also consider how this may play out differently in states that have a duals/LTSS specific program versus states with Medicaid managed care programs serving TANF and duals together. CMS should also provide more information and detail about how the new parameters will impact states with programs that are partially capitated or populations that are enrolled in D-SNPs but may be carved out of Medicaid managed care programs, such as dual eligible beneficiaries with IDD.
- State Medicaid policy, including managed care policy may be located in an array of possible policy frameworks – state contracting guidelines, state Medicaid regulations, or in state statute. Depending upon the complexity and location of authority which must be modified to comply with CMS' new requirements, states' ability to comply will vary notably in term of time frames. Further, states may not be aware of or planning ahead for how current state procurements may impact or be impacted by the new parameters for proposed changes in aligned enrollment in 2027 and 2030. States planning movement to an MLTSS system may also find complications in how those programs will be affected by these new parameters.
- We also suggest CMS consider some comprehensive approaches to working with states on provider and beneficiary educational materials associated with these changes. Providers often receive confusing guidance from states which do not align with plan communications. The SNP Alliance urges CMS to develop template educational materials for providers and beneficiaries to reduce confusion, challenges with provider networks, and loss of beneficiary enrollment during the transition to the new framework.

Changes to the Special Enrollment Periods for Dually Eligible Individuals and Other LIS Eligible Individuals (Pages 78568-78570)

CMS Proposal: CMS proposes two Special Enrollment Period (SEP) changes in order to address to aggressive marketing issues, the need to further protect Medicare beneficiaries, to reduce complexity for States and enrollment counselors, and to promote integrated care.

- The first change would replace the current quarterly special enrollment period (SEP) with a one-time-per month SEP for dual eligible individuals and other LIS eligible individuals to elect FFS and a standalone PDP. (LIS individuals without Medicaid could still elect any MA plan during ICEP or AEP or can switch plans during MA-OEP but could not elect an MA plan mid-year.)
- The second change would create a new integrated care SEP to allow dual eligible individuals to elect an integrated D-SNP (FIDE, HIDE or AIP) on a monthly basis. Dual eligible individuals could still enroll in non-AIP CO only D-SNPs or other MA plans during the ICEP, AEP or where another SEP permits.

CMS is also considering using a different enrollment effective date for the proposed integrated care SEP. CMS requests comments on the proposed changes to the dual SEP, the proposed integrated care SEP, and their combined impacts.

SNP Alliance Response:

- The SNP Alliance has long supported CMS efforts to increase enrollment alignment in integrated Medicare Medicaid plans. Without enrollment alignment, the benefits of integrated Medicare and Medicaid D-SNPs cannot be achieved. This SEP proposal will benefit integrated D-SNPs and along with the look-alike changes, can help reduce marketing activity directed at dual-eligibles away from MA-PDs in favor of D-SNP enrollment. While there is some potential for increased enrollment changes moving from quarterly SEPs to the continuous monthly SEP, enrollment changes between integrated plans as allowed here have not been a significant problem. Under the quarterly SEP there has been confusion for beneficiaries, plans, states, and enrollment assistors such as SHIPs and brokers in tracking allowable SEPs because currently there is no “source of truth” for documenting which SEPs have been used and when. Under this proposal, tracking such changes would be somewhat simpler and enrollment policies would be clearer to beneficiaries.
- While the SNP Alliance supports this change for full benefit dual-eligibles (FBDEs), FIDE, HIDE and AIP plans, we are concerned about the impact of this proposal’s further enrollment restrictions for partial-benefit dual eligible individuals. We would support allowing a continuous SEP for partial benefit duals for the purpose of enrolling in a CO-DSNP. This would help to clarify the important role that CO-DSNPs can play for the future as states build on them for further integration efforts, as well as promote the value of the assessment, care coordination and clinical management of chronic conditions that can be provided through the CO-DSNP Model of Care, resources that are not available to partial-benefit duals enrolled in MA-PDs.
- CMS should also monitor whether these SEP changes lead to unanticipated consequences such as those identified by CMS in its preamble including difficulty for enrollees who need to change plans to meet specific needs, frequent enrollment changes disrupting care coordination, and fewer plans investing in integrated programs out of concern for additional turnover of high-cost enrollees. Specifically, we recommend that CMS should monitor the following areas:

- Continuity of Care. The model of care for full duals has been thoughtfully designed by CMS and states to allow time for a new-to-plan member to explain their health and health-related needs and establish a plan of care that will support them in improving and maintaining their wellbeing. Members who switch plans at the end of the first, or even second, month of enrollment will not realize the benefits of enrolling with an integrated plan. CMS should monitor the proportion of short-term enrollments to assess whether continuity of care is being disrupted.
- CMS should also consider how the changes impact enrollees in states without Medicaid managed care.
- CMS should request information from states initially and periodically to ascertain whether monthly enrollment is operationally difficult for states to support.

Enrollment limitations for non-integrated Medicare Advantage Plans (Pages 78570-78575)

CMS Proposal: Citing the number of misaligned plan choices and the large number of dual eligible enrollees in coordination only D-SNPs and misaligned plans and service areas and marketing of numerous plan options in the same service areas resulting in choice overload, CMS proposes new regulatory requirements applicable at the parent organization level to MAOs that have non-integrated D-SNPs and affiliated MCO contracts, requiring the non-integrated D-SNP to limit new enrollment to dual eligible individuals enrolled (or in process of enrolling) in the affiliated MCO.

- Effective 2027, these dual individuals would not be able to select a misaligned D-SNP.
- Effective 2027, CMS will contract with only one D-SNP for full benefit duals in the same service area as the affiliated Medicaid MCO (including overlapping areas) with some exceptions as required by SMACs such as differences in eligibility (age) or benefits (partial-benefit duals).
- Effective 2030, these D-SNPs would also need to disenroll individuals not enrolled in both the D-SNP and the affiliated MCO (except for deemed eligibility for temporary loss of Medicaid).

CMS also proposes a new crosswalk to authorize MA organizations that are subject to these new enrollment limitations to crosswalk their enrollees to a single D-SNP to accomplish aligned enrollment and which could also be used to facilitate movement of partial benefit dual eligible individuals into coordination only D-SNPs. D-SNPs that limit enrollment to duals in affiliated Medicaid MCOs also cannot newly offer another D-SNP for full benefit dual-eligibles (FBDEs) if it results in non-compliance with these provisions.

Organizations that offer both HMO and PPO D-SNPs may continue to offer both only if they no longer accept new FBDEs in the same service area as the D-SNP affected by this new regulation.

SNP Alliance Response:

- The SNP Alliance supports CMS' general approach to this proposal to further align enrollment and promote enrollment into integrated programs. These new CMS level provisions reinforce what some states are already doing in their SMACs, but CMS also reinforces their own contracting authorities to apply these requirements and limits directly to MAOs at the parent company level.
- The SNP Alliance appreciates the crosswalk to enable non-FBDEs to enroll into CO-SNPs offered by the same sponsor.

- We also value that CMS is considering updates to the systems and supports designed to aid individuals in making Medicare choices such as MPF, HPMS, and other resources that help to outline available plan choices to individuals, SHIP counselors, and others. Please see our detailed comments on choice architecture in Section D.

Enrollment Processes: Members note considerable confusion about the enrollment and disenrollment processes to be used to achieve aligned enrollment. It is not clear which entity, the Medicaid MCO, or the Medicare D-SNP, drives some sort of auto-enrollment process. CMS should provide clarification and guidance for how this will work when enrollment in an MCO is mandatory, or an optional choice, or where the state has a passive with opt out enrollment process. CMS should be explicit about how the D-SNP enrollment choice will be considered in these processes.

For example:

1. In 2027:
 - a. How will the alignment work from a process perspective? If a Medicaid member becomes dual eligible effective on or after 1/1/27, to achieve aligned enrollment, will they be auto-enrolled in the Medicare D-SNP that aligns to their Medicaid MCO?
 - b. Or will they have to go through the Medicare application and sales process to choose a Medicare D-SNP and then be auto-enrolled in the Medicaid MCO that aligns to their Medicare D-SNP?
 - c. In states with voluntary Medicaid managed care would this mean that plans doing the right thing and participating in Medicaid managed care would lose any duals who choose not to be in Medicaid managed care?
 - d. What happens where states use the D-SNP Medicare choice to drive enrollment?
 - e. How will state enrollment time frames impact outcomes? What if the Medicaid enrollment period is not aligned with OEP for example?
 - f. How are partial capitation programs handled in this new enrollment policy?
 - g. How will enrollment be handled for D-SNP enrollees who are carved out of Medicaid managed care programs, or who have some benefits carved out that do not meet FIDE or HIDE standards for integration, but want to remain in D-SNPs for Medicare? Will CMS policies assist them in staying in a CO-DSNP without disruption?
2. In 2030:
 - a. How will existing members be aligned effective 1/1/2030? Upon which plan will the individual's aligned enrollment be based? For example, will dual eligible individuals be auto-enrolled into an aligned Medicare D-SNP or into an aligned Medicaid MCO?
 - b. Would they remain in their Medicaid MCO, and be disenrolled from their Medicare D-SNP if it is not aligned with their Medicaid MCO parent company or vice versa?
 - c. How will the process work for new members from a shopping perspective? Will they choose their plan via the Medicare application/sales process? Or will

Medicare enrollment be based on which Medicaid MCO they choose or are already enrolled in?

- d. In states that do not allow dual-eligible individuals to enroll in Medicaid MCOs, would the state be required to have a direct contract with the D-SNP so that dual-eligibles could participate in an integrated D-SNP?

We urgently request that CMS provide clarification of these questions and provide significant additional guidance at the detailed level necessary to better understand how the enrollment processes will operate to achieve the goal of aligned enrollment. We would be very concerned if the result of these policies is to disenroll dual eligible beneficiaries or partially dual eligible individuals who are enrolled in D-SNPs but due to state Medicaid policy designs do not meet criteria for enrollment in integrated programs, leaving only an MA-PD or FFS for their Medicare choice. We urgently request that CMS ensure their access to a CO-DSNP instead in order to provide continuity of care and benefits, and that CMS require that states provide a CO-DSNP option for enrollees in these circumstances, thereby recognizing CO-DSNPs as the appropriate Medicare platform for meeting their needs.

Partial-Benefit Dually Eligible Individuals: The SNP Alliance is concerned that increased market consolidation related to Medicaid procurements as part of this effort could squeeze out valuable CO-DSNPs which can serve as pathways for states and for offering care coordination for partial-benefit duals as well as full benefit dual eligible individuals who do not meet criteria for enrollment in integrated Medicaid MCOs as discussed above.

- We appreciate that CMS has allowed for CO-DSNPs to operate in the same service areas as integrated D-SNPs, though this does not go far enough in providing equity of access for partial-benefit duals to CO-DSNP care coordination through the models of care.
- The SNP Alliance requests that CMS require states to offer CO-DSNPs as an option for partial-benefit duals as a condition of application of these requirements, especially in those states that are moving towards exclusively aligned enrollment. A requirement for states to allow and approve separate PBPs for CO-DSNPs would enable access parity for partial-benefit dual individuals to enable enrollment in CO-DSNPs throughout this transition and beyond. As part of this requirement, CMS should educate states about the value of care coordination and Models of Care including the value continuity of care for those that shift to full benefit dual status that CO-SNPs can provide to partial dual eligible individuals. CMS should propose regulatory provisions as needed to ensure that this enrollment choice remains available to partial-benefit dual individuals.

Interactions and Unintended Impacts: The SNP Alliance continues to be concerned about the impacts on beneficiaries, states and plans of these changes because there are many moving parts where impacts are hard to predict due to the interactions between local market dynamics, state policy and authorities, and Medicaid MCO procurement and contracting choices. We are especially concerned that that these changes could result in unanticipated disruptions where states are making progress toward integration, including those states moving from the FAI to D-SNP models.

Further, states may not be aware of or planning ahead for how current state procurements may impact or be impacted by the new parameters for proposed changes in aligned enrollment in 2027 and 2030. In addition, states planning movement to an MLTSS system may also find complications in how those programs will be affected by these new parameters.

We suggest that CMS map out various scenarios that may occur as these changes are implemented in order to better anticipate any issues that may arise. We do not believe CMS would want to set back these existing efforts, so we request that CMS consider what authorities they may have to utilize strategies to mitigate such disruptions and if such authorities are lacking, they should propose solutions in response to this concern as part of the final rule process or as part of an additional rule making process prior to implementation.

Therefore, the SNP Alliance requests that CMS assess the following risks and work with states and plans to develop mitigation strategies where necessary.

1. How would CMS address concerns about state procurement impacts on plan participation resulting in further market consolidation in both Medicare and Medicaid?
2. How would CMS address concerns that this market consolidation could squeeze out high performing D-SNPs with deep expertise in specialized areas such as MLTSS and behavioral health?
3. Could this lead to more look-alike plans? If so, what are the mitigation strategies?
4. Even with specialized crosswalk provisions, this could result in disruptions for some beneficiary care, how can those best be addressed?
5. How will CMS assure access for partial duals and duals not eligible for integrated Medicare programs who wish to stay in CO-SNPs?

The SNP Alliance entreats CMS to monitor and report on the impact of these changes, to inform the SNP Alliance and others of any impacts and propose additional solutions where choices are narrowed and creating barriers to adequate beneficiary choices and/or overall integration goals.

D. Comment Solicitation: Medicare Plan Finder and Information on Certain Integrated D-SNPs (Page 78575-78576)

CMS Proposal: CMS is requesting comments on Medicare Plan Finder (MPF) for integrated D-SNPs. MPF is an online tool designed to help people with Medicare understand what coverage options are available to them. However, this tool is particularly challenging to navigate if you are dual-eligible—having both Medicare and Medicaid coverage. People who are dual-eligible have more complex coverage decisions and options than other MA enrollees. Medicare Plan Finder, in its default form, does not allow for dual-eligible beneficiaries to easily search for dual-eligible Special Needs Plans (D-SNPs).

SNP Alliance Response:

- The SNP Alliance believes changes need to be made to the Medicare Plan Finder to increase its utility for people who are dual-eligible. People who are dual-eligible have more complex coverage decisions and options than people who are only on Medicare.
- The SNP Alliance has been working with CMS on improvements to Medicare Plan Finder (MPF). Our comments also reflect information also found in Section C of this proposal, “A search of available options in Medicare Plan Finder (MPF) for a dual eligible individual in a zip code in this State yields 69 MA–PD options, including 19 D–SNPs” (Page 78571).

- The SNP Alliance suggests that the first change to Medicare Plan Finder (MPF) be a filter that separates D-SNPs and Medicare Advantage plans. The filter feature should display available D-SNPs first for people who are dual-eligible.
- Our second request for Medicare Plan Finder is to prioritize D-SNPs by level of integration with Medicaid in the search function for people who are dual-eligible and note the level in which the plan is integrated with Medicaid (e.g., a D-SNP that can be fully integrated with Medicaid).
- The SNP Alliance believes that Medicare Plan Finder should provide a more complete picture of the benefits available to people who are dual-eligible. We request MPF add more information about supplemental benefits that would allow people who are dual-eligible to understand a fuller picture of the benefits they would receive with each plan, inclusive of Medicaid benefits.

Additionally, the SNP Alliance would like to offer feedback to CMS on other ways to improve the Medicare Plan Finder for people who are dual-eligible:

- On the “Help with your costs” page, the current structure does not allow users to select multiple options. Many people are eligible for multiple programs listed, like both Medicaid and the Medicare Savings Program. The current structure forces one option, confuses users, and eliminates plan results in some areas.
- If a user selects that they receive help with costs from another program, the costs shown on the plan results page should reflect this help. For example, currently, if a user selects that they are enrolled in the Medicare Savings Program, Medicare Plan Finder still shows Part B premiums on the results page, for which a beneficiary is not responsible.

E. Comment Solicitation: State Enrollment Vendors and Enrollment in Integrated D-SNP (Page 78576-78578)

Current Opportunity for Use of State Enrollment Vendors for Enrollment in Integrated D-SNPs (Page 78576)

CMS Proposal: CMS is seeking feedback on the feasibility of requiring integrated D-SNPs to contract with State enrollment brokers as well as any specific concerns about State implementation. CMS acknowledges technical challenges that can impede the ease of enrollment into integrated SNPs, including misalignment of Medicare and Medicaid processes, start dates and related operational challenges creating challenges for D-SNPs with EAE because of difficulties in coordinating enrollment separately with the affiliated MCO. Citing the fact that some states have experience in using their enrollment vendors to assist with the process, including experience under the FAI and that states are currently allowed to require D-SNPs to contract directly with state enrollment vendors under certain regulatory parameters.

SNP Alliance Response:

- The SNP Alliance would like to acknowledge that enrollment will shift to D-SNP responsibility as plans transition from MMP to FIDE/HIDE SNPs and will likely follow or more closely align with the D-SNP enrollment process. This may mean there will be some loss of connection with the state’s Medicaid enrollment process creating additional challenges to integrated enrollments.

- For D-SNPs, Medicaid enrollment verification will also differ between states. There are states that have MLTSS plans and want to align Medicaid MLTSS plan enrollment with the D-SNP (HIDE/FIDE SNP) and there are states that do not have MLTSS and are contracting with the D-SNP directly to provide Medicaid services through the SMAC (MIPPA) contract.
- In both cases, however, the D-SNP will need to verify Medicaid enrollment, and Medicaid plan enrollment for states offering MLTSS, during the initial D-SNP enrollment process. In cases where this state process is in place, the vendor can perform these functions, reducing burden on the plan. However, not all states have a vendor system in place.
- We emphasize that it is essential that requirements for such enrollment systems and vendors include necessary oversight, monitoring, and protections to assure accountability to plans as well as to states and CMS to ensure timely and appropriate processing of enrollments.

Medicaid Managed Care Enrollment Cut-Off Dates (Page 78577)

CMS Proposal: Alignment of Medicare and Medicaid managed care enrollment dates poses current challenges around timing and effective dates causing month long lags for example, causing confusion for enrollees, and operational issues for plans and provider billing issues. CMS asks for information on reasons for these Medicaid cut off dates, and barriers and solutions to aligning these start and end dates and invites comments from States, D-SNPs and MCOs on their specific operational challenges related to potential changes to Medicaid cut-off dates so align them with Medicare.

SNP Alliance Response:

- The SNP Alliance has frequently pointed out issues with alignment of enrollment processes and effective dates in integrated programs. This is one of the many operational barriers that complicates the administration of integrated programs for states, plans, providers, and enrollees. Therefore, we applaud CMS for this comment solicitation and view it as a tremendous opportunity for all parties involved.
- Our members include several experienced plans with this approach and we encourage them to provide more detail for this highly technical topic. Examples include:
 - Requiring the MCO to send the D-SNP member file to the state and having the state enroll the members into the Medicaid plan and then returning the eligibility file back to the MCO would support an improved member experience.
 - Recommend eligibility action taken on the D-SNP to be sent by the MCO to the state to update the Medicaid plan (e.g., enrollment, disenrollment, eligibility changes including group number changes and loss of Medicaid). These eligibility changes can then be loaded to the MCO D-SNP Enrollment database, which will create internal synchronization and allow room for reconciliation which will, in turn, lead to a higher quality coordinated approach.

F. Clarification of Restrictions on New Enrollment into D-SNPs via State Medicaid Agency Contracts (SMACs) (§§ 422.52 and 422.60) (Page 75878)

CMS Proposal: CMS is proposing rule revisions that will enable State Medicaid Agency Contracts (SMACs) to clarify enrollment requirements into D-SNPs, especially new enrollment. Current regulations

require that D-SNP enrollees must meet enrollment requirements included in the State's Medicaid agency contract (SMAC) between the State and the D-SNP such as eligibility categories or other criteria consistent with the SMAC and this requirement has been there since D-SNP were created.

CMS aims to further clarify these regulations by proposing rule revisions to be explicit that to elect a D-SNP, an individual must also meet any additional eligibility requirements established in the SMAC and that SNP organizations may restrict enrollment in alignment with § 422.52(b)(2).

SNP Alliance Response:

- The SNP Alliance supports this clarification. However, we ask CMS to be cognizant of state Medicaid procurement practices, time frames, and any underlying state regulations. Compliance with a new federal requirement may take time depending upon re-procurement time frames, contract amendment processes, and any state regulatory policies which need to be updated for this purpose.

G. Contracting Standards for Dual Eligible Special Needs Plan Look-Alikes (§ 422.514) (Page 78578-78582)

Reducing Thresholds for Contract Limitation on D-SNP Look-Alikes

CMS Proposal: Based on evidence of extraordinary growth in the number of MA-PDs reaching and exceeding current look-alike thresholds since 2019, as well as comments from MACPAC and others about the need to simplify choices, reduce confusion and promote integration options for beneficiaries, CMS proposes to lower the D-SNP look-alike threshold from 80 percent to 60 percent incrementally over a two-year period.

- CMS would place a limitation on non-SNP MA plans with 70 or greater percent dual eligible individuals for contract year 2025.
- For contract year 2026, they propose to reduce the threshold from 70 percent to 60 percent or greater dual eligible enrollment as a share of total enrollment.

CMS also solicits comments on whether an alternative to reduce the threshold below 60 percent to 50 percent is more appropriate to protect against plans circumventing the requirements for D-SNPs while enrolling a disproportionate number of dual eligible individuals and on an alternative to apply the 60% threshold in 2026, use the current transition authority for 2025 and limit the use of the transition to move dually eligible enrollees only into D-SNPs in 2026 and beyond to provide plans more time to set up D-SNPs.

SNP Alliance Response:

- Historically, the SNP Alliance has supported lowering the threshold to 50%. We support CMS's position in the proposal of 60 %. However, we think moving incrementally to the 60% mark over the two-year period is reasonable.
- We support this additional step CMS is taking in reducing the threshold further to a 70 % threshold of dual eligible individual enrollment for look-alike plans for 2025 and to 60% in 2024.
- The SNP Alliance has commented over several years on issues related to the practice of MA-PDs creating look-alike plans which market to dual eligible individuals, often directing them away from

enrollment and models of care designed to serve them in integrated D-SNPs and engendering confusion over plan offerings.

- The SNP Alliance looks to CMS for the opportunity to strengthen the role of CO D-SNPs and sees the proposed restriction of transition cross walks in 2027 as an opportunity. Allowing transitions only to D-SNPs as a pathway of opportunity for partial-benefit duals enrollment into CO D-SNPs, bolsters CO D-SNPs as a conduit and platform for increased work with states.

Amending Transition Processes and Procedures for D-SNP Look-Alikes

CMS Proposal: CMS proposes to apply its existing transition processes and procedures at § 422.514(e) to non-SNP MA plans that meet the proposed D-SNP look-alike contracting limitation of 70 percent or more dual eligible individuals effective plan year 2025 and 60 percent or more dual eligible individuals effective plan year 2026 to minimize disruption due to the prohibition on contract renewals for existing look-alikes. For 2027 and subsequent years, CMS proposes to limit the § 422.514(e) transition processes and procedures to D-SNP look-alikes transitioning dual eligible beneficiaries into D-SNPs.

SNP Alliance Response:

The SNP Alliance will continue to advocate for D-SNPs to be able to keep serving partial-benefit duals and to push states to recognize the value of the MOCs and its care coordination for partial-benefit individuals. As states increasingly look to limit the number D-SNP plans, and CMS implements policies (like limiting to a single PBP without state policy change), it is becoming more difficult to serve partially dual eligible beneficiaries, thereby creating disparities for them. Therefore, we reiterate our requests to CMS for policies that strengthen enrollment into CO-DSNPs as the platform for serving partially dual individuals as outlined below.

- We appreciate the CMS statement in this rule allowing side by side PBPs in the same service area for partial-benefit duals and FBDEs. We also support CMS' proposal to limit the transition process to facilitate enrollment of dual eligible enrollees into D-SNPs. We add our previous request that CMS create a special monthly SEP especially for partially dual beneficiaries enrolled in an MA-PD to enroll in a CO-DSNP to help reduce creation of look-alike plans.
- The SNP Alliance notes that without strong look alike requirements, more partial-duals are likely to enroll in MA-PDs not designed for their needs, where there are no care coordination and MOC requirements, depriving them of access to those services as well as to specialized supplemental benefits compared to full benefit dual individuals.
- We reiterate our earlier request in Section C.2. that CMS require states to offer CO-DSNPs as an option for partial-benefit duals as a condition of enrollment alignment, especially in those states that are moving towards exclusively aligned enrollment so that partial-benefit duals have access to the same care coordination assistance.
- The SNP Alliance requests that CMS direct ICRC to work with states to promote and facilitate state adoption of enrolling partial-benefit dual individuals in CO D-SNPs.

H. For D-SNP PPOs, Limit Out-of-Network Cost Sharing (§ 422.100) (Page 78583)

CMS Proposal: CMS proposes that PPO D-SNPs must cap out-of-network cost sharing for specific provider types and services at various limits. CMS is also considering a requirement to limit all D-SNP

PPO out-of-network cost sharing to Traditional Medicare or using a limit specifically for physician services.

CMS is moving forward with the proposals outlined even though some cost sharing would be higher than Traditional Medicare, to mitigate negative impacts on D-SNP PPO enrollees as D-SNPs redirect funds from other supplemental benefits reduce this cost sharing. The new limits would be implemented for the 2026 plan year. CMS also requests comment on whether additional out-of-network services should be limited to levels in Traditional Medicare.

SNP Alliance Response:

- The SNP Alliance supports limiting out of network cost sharing for D-SNP PPOs, which benefits both providers and dual eligible beneficiaries who are not QMBs and may have to pay out of pocket. Higher cost sharing raises costs for Medicaid and dual eligible individuals who are not QMBs and are liable for cost sharing if they go out-of-network to providers not enrolled in Medicaid. It also disadvantages out-of-network safety net providers where state limits result in no state cost sharing payment, or disincentivize providers from serving dual eligible beneficiaries.
- The SNP Alliance also asks CMS for guidance on the following:
 - Develop model educational materials for plans.
 - Monitor provider access implications of caps and act upon negative impacts.
 - Monitor plan dollar shifts from supplemental benefits to cost sharing and impacts and act upon negative impacts.