

Special Needs ——— ————— Plan Alliance

VIA ELECTRONIC SUBMISSION:

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

Re: CMS-4208-P

RIN 0938-AV40

Acting Administrator Jeff Wu
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-4208-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Acting Administrator Wu,

The Special Needs Plan Alliance (SNP Alliance) is pleased to offer our comments on CY 2026 Parts and D Notice of Proposed Rulemaking (NPRM). The SNP Alliance is a national, non-profit thought leadership organization addressing the needs of high-risk and high-cost complex care populations through specialized managed care and is the only organization exclusively representing Medicare Advantage Special Needs Plans – Dual SNPs, Institutional SNPs, and Chronic Condition SNPs.

We represent approximately 65% of all SNPs. These plans have over 4 million beneficiaries enrolled across the country—totaling more than 55% of the national SNP and Medicare-Medicaid Program demonstration enrollment. Our primary goals are to improve the quality of service and care outcomes for complex care populations and to advance integration for those dually eligible for Medicare and Medicaid.

The SNP Alliance applauds the Trump Administration’s focus on Medicare Advantage Plans and complex care populations which SNPs serve, only. We look forward to a positive, solutions-oriented relationship with President Trump’s incoming leadership on these vulnerable high populations.

And, as part of our dialogue, we will provide thoughtful input on how best balance the need for government efficiency while ensuring access to high quality care for America’s citizens with complex care needs. To date, we have had a positive working relationship with senior CMS officials in the Center for Medicare and the Medicare-Medicaid Coordination Office (MMCO) and, also, look forward to continuing these relationships.

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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:

- The Medicare Prescription Payment Program language does not address SNP beneficiaries. Redefining the “likely to benefit” provision to exclude LIS members, dual eligible individuals, or FIDE/HIDE plan members who already receive limited cost sharing. This clarifying language would decrease improper enrollment in the MPPP.
- Proposed marketing restrictions on Debit card dollar values for supplemental benefits may inadvertently harm beneficiaries and reduce transparency for consumers, who have a right to be fully informed of the value of the benefits before making a decision to enroll in a health plan.
- Including information about direct furnishing entities (DFEs) offering in-home or at home services in future provider directories. However, this policy does not utilize existing directories and databases available at federal, state, and region levels. Adding DFEs to provider directories would actually be redundant, inefficient, and administratively burdensome.
- We believe that the expansion of health equity analysis in utilization management policies and procedures is premature. Previous years’ rules have not yet been implemented. UM Committees and health plans need time to work through the processes and approach from the previous policy around health equity analysis.
- We believe that dual-eligible individuals can benefit greatly from increased integration and smart integration. The SNP Alliance supports CMS’ proposal to only require D-SNPs that are exclusively aligned AIPs to implement integrated health risk assessments (HRAs). This proposed requirement is too operationally complex for HIDE SNPs or all D-SNPs now.

While not part of the NPRM and, therefore open to comment, the SNP Alliance highlights CMS’s decision to abruptly end the Value-Based Insurance Design (VBID) model for plan year 2026. In CMS’s announcement regarding the end of the VBID program, it was indicated that enrollees will likely be able to access many of the same benefits after VBID’s termination under the uniformity flexibility or supplemental benefits for the chronically ill (SSBCI).

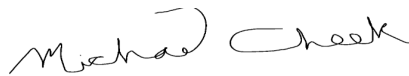
The elimination of VBID will result in a significant contraction in SSBCI due to reduced plan resources negatively impacting the complex populations served by SNPs. Such reductions likely will impact enrollment and could negatively impact quality outcomes such as increased hospitalization and/or institutionalization driving up Medicare and Medicaid costs. As with other aspects of the Medicare Advantage Plan program, we look forward to collaborating with President Trump’s leadership on a pathway to continuing these critical benefits but recognizing the need for government efficiency. The SNP Alliance will submit further comment under separate cover and request meetings with President Trump’s health care leadership.

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The SNP Alliance is committed to improving the care and the lives of those most vulnerable complex care populations who are high-risk and have the highest-cost needs. Our comments are intended to be constructive and solutions oriented. We greatly appreciate CMS' thoughtful work on the NPRM and thank the Agency for affording stakeholders an opportunity to comment on the proposals related to the MA and Part D programs for 2026.

We welcome the opportunity to further expand on these recommendations with President Trump's leadership. For more information, please feel free to contact me at mcheek@snpalliance.org.

Respectfully,



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Section II. Implementation of IRA Provisions for the Medicare Prescription Drug Benefit Program

This SNP Alliance believes that access to necessary, timely, and affordable medications and vaccines is crucial to improve the lives of adults with complex care needs. We support the codification of regulation requirements from the Inflation Reduction Act (IRA) to minimize cost sharing.

A. Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices under Medicare Part D (§§ 423.100 and 423.120)

CMS Proposal: Codification of requirements from the Inflation Reduction Act (IRA) that:

- There is no cost sharing in Part D plans for the adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and
- The Part D deductible does not apply to these vaccines as of January 1, 2023.

SNP Alliance Response:

The SNP Alliance supports CMS' efforts to ensure older adults have no financial barriers to receiving recommended vaccines.

C. Medicare Prescription Payment Plan (§§ 423.137, 423.2265, 423.2267, and 423.2536)

CMS Proposal: Beginning with the 2025 plan year the program, Medicare Prescription Payment Plan (MPPP), allows all Medicare beneficiaries the opportunity to pay their out-of-pocket (OOP) costs through a series of monthly installment payments, rather than all at once at the point of sale.

This proposal institutes three new requirements that hope to aid in customer satisfaction through automatic renewal if there is no change in the plan benefit package, timely voluntary termination requests, and cost transparency.

SNP Alliance Response:

The SNP Alliance has provided CMS with feedback throughout the MPPP programmatic standup requesting language that addresses SNP beneficiaries particularly to decrease improper enrollment in the MPPP. The SNP Alliance is concerned that inclusion of D-SNP members in the outreach and education for the program when there is no practical applicability to them. SNP enrollees often receive a low-income subsidy (LIS) or other cost sharing subsidies to offset prescription drugs. These low-income cost sharing subsidies are often more advantageous than the MPPP.

Low education levels¹ and low health literacy comprehension is likely to create potential confusion about the MPPP program option. In the current rollout for the MPPP, there is not

¹ Differences in care between Special Needs Plans and other Medicare coverage for dual-eligibles - PMC (nih.gov)

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enough information that articulates the protocol for engaging with a D-SNP beneficiary. Without further education there is and will continue to be a lack of understanding from D-SNP LIS eligible enrollees about which program is best for their prescription drug needs.

The SNP Alliance is worried that the outreach and education for brokers, agents, and point-of-sale contacts is focused on program enrollment targets, not the best program for the D-SNP enrollees. Beneficiaries may be encouraged to sign up for the MPPP when it is not the program best suited for their needs.

The current outreach and enrollment timelines do not exclude outreach to the SNP population. We ask CMS to redefine the ‘likely to benefit’ provision of the MPPP program to exclude LIS members, dual-eligible individuals, or FIDE/HIDE plans, as cost-sharing for these plans is already limited. Waiving cost-sharing improves medication adherence, reduces disease burden, and lowers administrative expenses, ultimately resulting in Federal cost savings that exceed the value of the waived cost-sharing.²

Additionally, the termination of the Value-Based Insurance Design Model (VBID) at the end of 2025 will do away with benefit design and flexibility for LIS members in dual-eligible plans. Special needs plans will longer be able offer \$0 Part D copays. FIDE/HIDE health plans will be required to inform members about MPPP even though most members are LIS recipients and therefore unlikely to benefit. This will increase the risk that enrollees who are unlikely to benefit will enroll in the program. Feedback from our membership supports the SNP Alliance in requesting CMS explore a demonstration program that allows plans to waive part D cost-sharing for LIS members in FIDE/HIDE plans.

Section III. Strengthening Current Medicare Advantage, Medicare Prescription Drug Benefit, and Medicaid Program Policies

We must protect the Medicare program to make it sustainable for future generations. A new generation of seniors, approximately 10,000 per day, are moving into Medicare. Programs and policies need to be in place to meet their modern, savvy consumer expectations. Innovative tools, programmatic features, and new types of benefit must be offered to those expectations.

A. Part D Coverage of Anti-Obesity Medications (AOMs) (§ 423.100) and Application to the Medicaid Program

CMS Proposal: Currently, CMS does not allow for Part D coverage of medications for weight loss under provisions of Section 1860D-2(e)(2) of the Social Security Act. A new interpretation would no longer refer to anti-obesity medications (AOMs) when used to treat obesity. The phrase “agents when used for... weight loss” allows CMS to acknowledge that the prevalence of

² Fusco, N. et al. [Cost-Sharing and Adherence, Clinical Outcomes, Health Care Utilization, and Costs: A Systematic Literature Review](#) | National Pharmaceutical Council [Journal of Managed Care and Specialty Pharmacy](#), April 2022

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obesity in Medicare has increased in recent years, and to consider obesity to be a chronic disease. CMS proposes to reinterpret section 1927(d)(2) so that the weight loss language does not apply to anti-obesity medications (AOMs) for treating obesity.

Obesity also has a high prevalence in Medicaid. Across the nation, state Medicaid programs are electing to cover AOMs.

SNP Alliance Response:

Obesity is considered a chronic condition under the list of chronic conditions updated in the 2025 Final Rule. We support CMS' attempts to manage obesity as a chronic condition. With this knowledge, we ask CMS to clearly define obesity. We respectfully request CMS clearly define "obesity" for determining Medicare coverage eligibility. FDA labels do not typically define overweight or obese, making it difficult to determine whether a Part D sponsor's coverage criterion is within the label parameters. Standardized definitions are critically important to ensure plans serving dually eligible individuals appropriately split of costs for items and services that can be billed in part to Medicare and Medicaid.

We are concerned this ambiguity will result in inconsistent coverage criteria across the market, creating confusion for beneficiaries. Ambiguity will result in inconsistent reporting, challenges with crossover claims, and financial experience across D-SNPs and can lead to inaccurate Medicaid rate development.

With a thorough read of this proposal, we have several concerns that will impact special needs populations:

- We are concerned about the re-interpretation of the statute by CMS. We are anxious that by using the authority in this capacity it will open the door to challenges under the Loper Bright standard.
- In states where AOMs are covered, spending has been exorbitant. Additionally, the unwinding of continuous eligibility has exacerbated existing funding struggles related to Medicaid rates.³ Several states have explored coverage but have ultimately chosen not to extend coverage due to budget concerns. The budget impact of extending coverage is material to state Medicaid budgets due to the high costs of AOMs and the anticipated high demand. States must have time to appropriately budget for such a change.
- Morbid obesity is the existing HCC. But that is a medical HCC, not an RX HCC. We ask CMS to articulate funding questions related to coverage of GLP-1s.

The SNP Alliance asks for clarification or the establishment of criteria for coverage when a beneficiary loses weight while on an AOM, and they no longer meet the coverage criteria (e.g., are no longer obese). We are concerned about physical, mental, and emotional cycle beneficiaries may go through the starting and stopping of AOMs when they no longer meets the label or other definition of overweight or obese.

³ [Which State Medicaid Programs Cover GLP-1s Approved for Weight Loss & How Much Are They Spending?](#)

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The SNP Alliance is dedicated to reflecting the needs of our members and the beneficiaries they serve. This proposal will add substantial financial liability for Part D sponsors. In a report released in October 2024, the Congressional Budget Office estimated that “authorizing coverage of AOMs in Medicare would increase federal spending, on net, by about \$35 billion from 2026 to 2034.” They also point out that “Relative to the direct costs of the medications, total savings from beneficiaries’ improved health would be small—less than \$50 million in 2026 and rising to \$1.0 billion in 2034.”⁴

Additionally, utilization rates are difficult to predict for a drug that has never been covered in the program before for this indication. We suggest delaying the coverage of anti-obesity medications in Medicare until there can be alignment with:

- Medicaid—Different effective dates for coverage of AOMs under Medicaid and Part D in Medicare, would require Medicaid programs to provide the AOM coverage for certain dually eligible individuals until Part D coverage begins. The new coverage requirement would take effect in Medicaid 60 days after the final rule is published.
- Inclusion in the drug price negotiation program—One challenge with this is data on AOM spending. Per current guidance from CMS, AOMs, like Wegovy, cannot be added to the drug price negotiation list until there’s a record of their spend. With this in mind, it will be several years until price negotiation could take effect.

The SNP Alliance would like to express our concerns with the precedent set by CMS’ proposal to reinterpret a statute. This could lead to future significant changes to the Medicare program without clear Congressional intent. The reinterpretation of AOM coverage introduces substantial costs and operational challenges for plans. Our membership has already observed a dramatic rise in demand for Part D-eligible GLP-1 medications, often prescribed for weight loss. We strongly recommend that CMS consider the financial implications of this proposal and focus on affordability measures before finalizing changes to AOM coverage.

B. Network Transparency for Pharmacies

CMS Proposal: Part D sponsors would be required, by October 1, to let pharmacies know if they will be in-network for the plan for the following year. Pharmacies would also be allowed to ask Part D sponsors for a list of in-network plans after October 1. The information to be provided to a network pharmacy would include the contract number, plan ID, and the marketing name for each plan sponsor.

SNP Alliance Response:

The SNP Alliance would like CMS to clarify the timing for communications. Our membership has expressed concern that this requirement could create operational challenges for SNPs to meet these obligations. The October 1, 2025, implementation date for this requirement could hinder the contract negotiations already underway. Additionally, the time frame of the notifications

⁴ <https://www.cbo.gov/publication/60816>

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could create a competitive disadvantage through patient-steering and ultimately drive cost. Beneficiaries could become pawns to enhance revenue.

E. Modifying the definition of “Service area” § 422.2

CMS Proposal: CMS is proposing to amend the definition of service area in § 422.2 to refer to “a geographic area that for local MA plans is one or more counties, as defined in § 422.116(a)(1).” CMS currently defines, in § 422.2, service area to include “a geographic area that for local MA plans is a county or multiple counties.”

SNP Alliance Response:

The SNP Alliance supports this amended change to the statute. Service area clarity is becoming increasingly important to special need plans, especially plans that service a dually eligible population.

F. Administration of Supplemental Benefits Coverage through Debit Cards §§ 422.2, 422.102, 422.102, 422.111, and 422.2263

CMS Proposal: CMS is proposing additional parameters on the debit cards that health plans use to administer supplemental benefits. The debit card itself is a tool used to administer coverage to an enrollee for identified plan-covered items and services at a reduced cost. Plans must offer user-friendly materials and a customer service number for beneficiaries to use for questions or issues.

CMS is also proposing that plans must have an alternative process that allows for reimbursement of eligible expenses for plan covered benefits—if there is an issue with a debit card. This alternative process must be in place for both in-network and out-of-network access to the benefit where necessary, and plans must disclose the alternative process by which reimbursement may be made to enrollees and to ensure that the process is accessible to all enrollees.

CMS is suggesting adding a new paragraph (b)(11) at §422.2263 prohibiting MA organizations from marketing the dollar value of a supplemental benefit or the method by which a supplemental benefit is administered, such as use of a debit card. Due to the ever growing and creative marketing strategies that rely on dollar amount to entice enrollment, CMS seeks to avoid beneficiaries seeing advertisements for a debit or flex card of a certain value, without understanding the limits on items and services, eligibility, etc. that come with such a card.

SNP Alliance Response:

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The SNP Alliance appreciates CMS's attempt to address consumer confusion and issues related to the marketing of MA supplemental benefits through debit card mechanisms. However, we are significantly concerned that the proposed marketing restrictions may inadvertently harm beneficiaries. Prohibiting supplemental benefit dollar value and directing debit card administration method in the health plan's marketing materials will counteract informed choice. The proposed restrictions would also reduce transparency for consumers, who have a right to be informed of the value of the benefits. Beneficiaries should be fully informed before making a decision to enroll in a health plan.

Beneficiaries often select plans by using side by side comparison of these supplemental benefits. Benefit values enable a clear understanding of the trade-offs between plans in the enrollment decision-making process. We hear from our member health plans that they are using dollar amounts on the debit or flex cards to attract enrollment and keep up with the market competition. The publication of allowance amounts or the use of a single debit card for multiple plan benefits is convenient and limits consumer confusion. Debit or flex cards are used for a myriad of non-health related social needs. Over-the-counter medications, groceries, and utilities payments are just a few of the supplemental benefits offered via debit card. The automated nature of debit cards ensures real-time validation of approved items at the point of sale. We encourage CMS to work with MAOs to develop clearer communication standards for describing these benefits and delivery methods rather than prohibiting their promotion. The SNP Alliance asks CMS to reconsider these proposals and focus on solutions that maintain the efficiency and practicality of current debit card systems while ensuring member satisfaction and ease of use.

Based on member feedback, the SNP Alliance alternatively suggests that CMS revise existing sub-regulatory guidance to provide clear examples of inaccurate or misleading supplemental benefit marketing that should be prohibited. Explicit examples of "what not to do" will encourage industry transparency.

Manual Reimbursement

The SNP Alliance agrees that there is more need for information and for consumer support to understand how to access benefits through a debit card. We are concerned that while the manual reimbursement method aims to promote ease of use for benefit dollars, it does not provide a way for members to know in advance if an item will be covered, potentially exposing them to unexpected out-of-pocket expenses. Mandating a manual receipt reimbursement process would require extensive administrative effort, including additional full-time staff, to review each item individually. Furthermore, current card vendors lack infrastructure to manage receipt reimbursements, meaning the burden would fall entirely on plans.

Manual reimbursement of covered OTC items via receipt is one example how very cumbersome and challenging it is to identify, verify, and validate a transaction for an approved item. For OTC benefits administered via debit card most MA plans offer a direct-to-consumer option, which allows members with the ability to order covered items for home delivery. However, using CMS's own example of Walmart or Costco, those store's systems are not designed for real-time electronic transaction inquiry to identify and verify eligibility at the point of sale and time of purchase. Additionally, receipts from large chain stores may not provide enough item details for

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the plan to validate its use. The onus would fall on the members to send proof—an image of the box or item label—to validate the item meets the eligibility requirements for reimbursement.

PPOs

Preferred Provider Organizations (PPOs) allow members to use healthcare providers outside of the network. In this proposal, CMS is considering allowing PPOs the flexibility of using any retailer to provide supplemental benefits rather than have a list of preferred retailers. Expanding benefits to any retailer would be complex. Some debit card vendors work across states and with a large cadre of retailers, but that extensive network could require plans to manually manage approvals and validations.

The SNP Alliance wants CMS to understand the additional administrative complexity that MA PPO plans face to maintain the efficiency of debit card systems and ensure satisfactory ease of use for members. We are concerned that this proposal could be construed as allowing members to shop outside the network for supplemental benefits under any circumstances.

G. Non-allowable Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)

CMS Proposal: CMS provides a non-exhaustive list of non-primarily health related items or services that do not have a reasonable expectation of improving or maintaining the health of a chronically ill enrollee and therefore cannot be offered as SSBCI. For example:

- Cosmetic procedures
- Alcohol, tobacco, and cannabis products;
- Funeral planning and expenses;
- Life insurance;
- Hospital indemnity insurance; and
- Broad membership-type programs inclusive of multiple unrelated services and discounts.

SNP Alliance Response:

The proposed policy, as stated, is ambiguous. We are concerned that this will more often negatively impact individuals who are dually eligible, and/or who have higher social determinants of health risk factors. The definition of what services “do not have a reasonable expectation of improving or maintaining the health of a chronically ill enrollee” is vague. This description, coupled with a non-exhaustive list of non-allowable services, does not provide enough guidance to be able to discern what may or may not be covered.

We note that there are non-medical services and items which can and do improve or maintain health—such as food, non-medical adaptive equipment (e.g., grabbers, raised toilet seats, door levers, motion detecting interior lights for hallways) which can and do help maintain function and avoid ill health/poor outcomes—but which could be denied as “non-allowable.” These services make a real difference in the lives of frail elderly and functionally limited individuals.

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Coupled with the additional restriction in Section H. of the proposed rule on eligibility, this policy could serve as a barrier to maintaining or improving health among people most in need.

We believe that this restriction on SSBCI services will disproportionately negatively affect special needs populations. The SNP Alliance urges CMS to reconsider this policy.

H. Eligibility for Supplemental Benefits for the Chronically Ill (SSBCI) and Technical Changes to the Definition of Chronically Ill Enrollee (§ 422.102)

CMS Proposal: CMS want to clarify the criteria necessary to be eligible qualify for a SSBCI. All three criteria must be met:

- (1) Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
- (2) Has a high risk of hospitalization or other adverse health outcomes;
- (3) Requires intensive care coordination.

SNP Alliance Response:

The intent of SSBCI, as we understand it, is to address social risk issues that exacerbate and accelerate chronic conditions and poor health outcomes. Special Supplemental Benefits for the Chronically Ill are part of a care management strategy, to help prevent functional decline that leads to adverse events such as falls, depression, and to improve self-care management of chronic disease. This helps avoid health decline that could lead to hospitalization or other adverse events.

As written in this proposed rule, access to and use of SSBCI will be restricted to such an extent that it may negate or severely limit the intended purpose. The implications for how these three criteria are being applied, compared to current standard operating processes, causes concern. Individuals enrolled in special needs plans have greater health risks and often face deficits in accessing food, stable housing, transportation, and other services such as in-home supportive care.

The SNP Alliance has observed reductions in the breadth and depth of SSBCI services being offered. The existing criteria and requirements placed on plans were already having a chilling effect on plan offerings. The rules around SSBCI are already restricting access. The proposed changes shrink this even further.

We do not believe the intent for the SSBCI policy was only to serve people with a recent hospitalization as an indicator of high risk. We would not recommend that recent hospitalization be used as an eligibility criterion for SSBCI, nor that the focus be on only the most recent medical episode. If a person must have a recent hospitalization to demonstrate “high risk,” then this seems to discourage preventive interventions that would help avoid such things as falls, for example through provision of balance classes (e.g., Matter of Balance), home-based functional status improvement programs (e.g. CAPABLE), or chronic care management education and group support (e.g., Chronic Disease Self-Management programs). Many of these relatively low-

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cost, evidence-based services have a 15-to-20-year history of demonstrating positive impact on falls prevention efficacy, better self-care management, improving functional status, and reducing depressive symptoms.

These proposed criteria and the added prerequisites could potentially delay access to SSBCI benefits. While we agree that members should be able to access information about plan-provided SSBCI benefits, we disagree that posting the objective criteria developed and used by the MA plan to determine eligibility for SSBCI is useful for the member. Alternatively, the SNP Alliance suggests that CMS require MA plans to develop and maintain content outlining available SSBCI and how the member can access benefits for which they might be eligible. This content would be available and updated on their public website and/or member portal dedicated to SSBCI. This approach coupled with provisions in the CY 2025 MAPD Final Rule—particularly the mid-year notice of unused supplemental benefits and the SSBCI disclaimer—could provide curated, organized, structure to ensure individuals are able to determine whether they might be eligible for an SSBCI.

In December 2024, CMS announced that it intends to end the Value-Based Insurance Design (VBID) Model by the end of 2025. It came as shock to the special needs plan community, especially since the program had just been reauthorized to continue until 2030. The SNP Alliance does not support this program termination decision and we strongly recommend CMS reconsider this course of action. However, if CMS chooses to continue with terminating the VBID, MA plans, including SNP and non-SNP plans, will look to SSBCI flexibilities as the primary avenue for non-health related benefits. SSBCI service and benefits will be even more critical to providing non-health related supports to Medicare beneficiaries, especially low-income beneficiaries.

It is the SNP Alliance's belief that the proposed criteria for eligibility and appropriateness of use for SSBCI benefits will only create more constraints on health plans and make it more difficult to implement CMS' intended transition away from VBID. We strongly encourage CMS to allow D-SNPs to offer non-primarily health-related benefits to the entire D-SNP population, to the extent possible under CMS' current authority.

J. Ensuring Equitable Access to Medicare Advantage (MA) Services – Guardrails for Artificial Intelligence (§ 422.112)

CMS Proposal: CMS is proposing to add a requirement for MA organizations to ensure services are provided equitably irrespective of delivery method or origin, whether from human or automated systems.

SNP Alliance Response:

The SNP Alliance supports equitable delivery of services. We support the policy but request CMS to collaborate with standards development organizations to foster development and alignment of best practices and standards for AI use and evaluation. Given the growing use of AI within the healthcare sector, we strongly agree that AI developers and plans must take steps to

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identify and address biases that are affecting equitable access to care for enrollees. This approach allows for flexibility, enabling organizations to make appropriate adjustments as technologies and use cases evolve, while still aligning with recognized standards and clinical practices to ensure equitable access.

Artificial Intelligence (AI) and automated systems have the potential to provide data-driven approaches that support more efficient and accurate health plan decision making, improving access to quality care. However, the proposed regulatory approach implies that it is possible to identify and eliminate all bias from AI and automated systems. It is not yet possible to eliminate all of the bias that exists in the real world as well as collect significant amounts of error-free data—so there will be biases in automated intelligence and in the standards and best practices used to train the model.

Based on feedback from our membership of health plans, we encourage CMS to mirror the approach taken by NCQA as part of their 2024 Health Equity and Health Equity Plus Accreditations, which requires that organizations that use AI implement a framework and policies that are fair and equitable to members. Recommended frameworks such as NIST AI Risk Management Framework <https://www.nist.gov/itl/ai-risk-management-framework>. This framework provides a structured approach to identify, assess, and mitigate the risks associated with AI systems; moreover, the NIST framework enables organizations to navigate the complicated world of AI technology while assuring ethical AI adoption, encouraging accountability and transparency when implementing AI, and protecting individuals' rights.

K. Promoting Community-Based Services and Enhancing Transparency of In-Home Service Contractors (§ 422.2, 422.111)

CMS Proposal: CMS proposes to add at § 422.2 a definition for a “direct furnishing entity” which means any individual or entity that delivers or furnishes covered benefits to the enrollee. This includes Medicare Part A and B covered benefits, as well as all types of supplemental benefits. This would include all benefits paid for by the health plan including SSBCI and extends this policy to any service that is “first tier, downstream, or related entities,” regardless of the status.

CMS particularly focuses on services that involve interaction with an enrollee at the enrollee’s home (for example, in-home support services, meal delivery, home modifications, individuals providing adult day care services) and notes that a safety risk exists for enrollees who may not have information about who (what individuals) may have access to their home, personally identifiable information (PII), or protected health information (PHI).

CMS proposes requiring that plans include all direct furnishing entities in their provider directories, and that the directory list each service provider’s cultural and linguistic capabilities, with a particular focus on providers offering in-home or at-home services.

SNP Alliance Response:

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The SNP Alliance supports partnerships with, and services provided by community-based organizations (CBOs) and other in-home service providers. Home-based services are important and frequently utilized by SNP populations. The SNP Alliance appreciates CMS' interest in ensuring enrollees have access to important information about direct furnishing entities (DFEs). However, this policy needs to be reworked to recognize existing roles and authority, utilize existing directories, and avoid inefficiencies and complications.

First, CMS policy should recognize that CBOs document, track, and monitor the services they provide in members' homes, and train their staff in how to handle protected health information and ensure privacy and safety of the individuals they serve. This is the responsibility of the CBO as the employer of these individuals going into the home—to ensure that their staff and volunteers are properly trained and to monitor their actions. The role and duty of the CBO that provides in-home services is similar to the role and duty of a certified home health care company that provides in-home skilled nursing or therapy services or a home-based primary care clinic. It is not the role, nor does the health plan have authority, to train and monitor employees of CBOs.

Second, while the policy is well-intended, it raises three key issues:

- Potential Conflict with State or other Agency Oversight
- Lack of Capacity to Train/Monitor Workforce of CBOs by Health Plans
- Duplication of Existing Directories/Databases & Lack of Feasibility

Potential Conflict with State or other Agency Oversight

Many if not most of the CBO and in-home service providers of supportive services are part of the State Medicaid home and community-based services and/or the aging and disability services systems—overseen by the State departments of health and/or human services, State Medicaid agency, and/or by the Area Agencies on Aging and Disability Resource Centers.

States already have the accountability and oversight for certifying home-based care providers under Medicaid rules. We do not recommend having health plans take on this certification or oversight role, as it could conflict with the State's policy, be duplicative, inefficient, and confusing to consumers, CBOs, and providers. Rather, we recommend that CMS work with States to indicate how they certify CBOs under state laws, regulation, and policies. Rather than having each health plan certify, track, or review every CBO providing home-based services, we recommend that CMS direct each State department of health or human services, to regularly review and certify that CBOs providing home-based services are in compliance with state and local laws, regulations, and policies and that the workforce has been trained on data privacy and safety rules around vulnerable adults. Such a certification would provide the assurance to consumers, health plans, other providers who may make referrals, and the general public, that there is consistent oversight and a set of standards that have been met.

Further, we recommend that CMS work with States, Area Agencies on Aging, and CBOs directly to identify best practices and provide resources and training to ensure that CBOs that provide home-based services are complying with state and local laws, regulations, and policies to ensure

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protection for their residents/clients. Health plans would welcome having one place to look to review CBO certification as governed by the State.

Lack of Capacity to Train/Monitor CBO Workforce

Health plans do not have the capacity or training to certify and oversee the actions of each staff member or volunteer employed by community-based organizations. We recommend that CMS direct health plans to use the information provided by the State on certification of CBO and in-home service providers.

Duplication of Existing Databases/Directories & Lack of Feasibility

The SNP Alliance does not recommend having health plans try to serve as a clearinghouse for CBO services by including such listings in a provider directory. Plan provider directories are for listing the certified providers who are in the health plan's network and under contract with the plan where consumers can schedule services. Such directories are not meant to be a clearinghouse of information on all local or regional services in an area. Expecting every health plan to list all possible "downstream" community-based service providers duplicates existing service databases and would be nearly impossible to keep up to date given the wide range of types of services involved and potential turnover of staff. Community based providers would have to update their information in every plan directory—this is inefficient and duplicates existing directories and databases.

There are already databases and directories maintained at federal, state, and regional levels. For example, *The Eldercare Locator* is a database that includes State Agencies on Aging, Area Agencies on Aging, Title VI Native American Aging Programs, Aging and Disability Resources Centers, and aging information and referral programs. It also includes special purpose information and assistance resources for legal services, elder abuse prevention, the State Health Insurance Assistance Program, and the Long-Term Care Ombudsman Program (See: <https://eldercare.acl.gov/public/about/database.aspx>)

In addition, the States already have their own searchable databases or 1-800 direct service referral lines. See, for example: Minnesota <https://mn.gov/senior-linkage-line/> , California [https://aging.ca.gov/Programs and Services/Aging and Disability Resource Connection/](https://aging.ca.gov/Programs_and_Services/Aging_and_Disability_Resource_Connection/) , Missouri <https://health.mo.gov/seniors/senior-resource-line.php>, Wisconsin <https://seniorresourcesonline.com/>. These have been developed over many years and are maintained at the state or regional level. CMS policy should encourage their use. This will reduce burden on the CBOs and encourage all interested parties to use the one online or searchable database and maintain that database regularly.

Therefore, to support the intent, we recommend that CMS propose a policy requiring the use of existing federal, state, and/or the Aging and Disability Resource Center databases on home and community-based service providers. CMS should direct health plans to direct consumers to services that are present in the online 24/7 searchable database on home-based services. Such databases describe home and community-based services throughout the state or region, generally provide search fields (such as by zip code or other filters), and usually provide information about whether the service is covered by Medicaid, the Older Americans Act, or other funder, and how

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to access the service. These databases may be maintained by the federal government (e.g., Eldercare Locator), or by State and/or regional or municipal agencies. Working smarter and more efficiently rather than creating redundant directories.

The SNP Alliance is troubled by the requirement to list subcontracted vendors or individual names. Particularly for supplemental benefits like SSBCI that often require care coordinator approval or referral rather than direct access. For example, plans may use a scheduling agency to arrange transportation for enrollees, who may in turn work with Uber, Lyft, or other ride service organizations. If plans are required to include subcontracted agencies in the directory, enrollees may see entities like Uber listed in the directory and directly contact them to arrange transportation services without realizing that the service will not be considered a covered service because it was not arranged through the plan, as outlined in the Managed Care Manual. The SNP Alliance entreats CMS to allow MA plans flexibility to strengthen the language in their directories articulating when enrollees should contact their care coordinator to access covered benefits through a provider. Clearer wording will support enrollees in understanding how to access their benefits, reduce confusion, decrease member/caregiver frustrations, and calm any service abrasions.

L. Ensuring Equitable Access to Behavioral Health Benefits Through Section 1876 Cost Plan and MA Cost Sharing Limits (§§ 417.454 and 422.100)

CMS Proposal: CMS is proposing that Medicare Advantage plans require in-networks cost sharing be no greater than that in FFS Medicare for specific service categories of behavioral health services. The proposed service categories are:

- Mental health specialty services
- Psychiatric services
- Partial hospitalization
- Intensive outpatient services
- Inpatient hospital psychiatric services (all length of stay scenarios)
- Outpatient substance use disorder services
- Opioid treatment program services.

SNP Alliance Response:

The SNP Alliance appreciates CMS' efforts for mental health parity. Behavioral health conditions were estimated to affect at least a quarter of the 66.7 million Medicare beneficiaries in 2023.⁵ The beneficiaries moving into Medicare more readily utilize behavioral health services. The national shortage of behavioral health workers across provider types and more than half of the U.S. population lives in a Mental Health Professional Shortage Area according to the Health Resources and Services Administration.⁶ The need for behavioral health services will continue to be needed. Therefore, we encourage CMS to address how the proposal's focus on cost-sharing

⁵ [Behavioral Health: Information on Cost-Sharing in Medicare and Medicare Advantage | U.S. GAO](#)

⁶ Behavioral Health Workforce, 2023. Health Resources and Services Administration (HRSA).
<https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf>

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will help tackle other critical challenges, such as the persistent shortage of behavioral health providers. Without concentrating on these broader issues, the SNP Alliance is concerned the proposal does little to ensure that beneficiaries have meaningful access to high-quality behavioral health care.

Dual eligible individuals with behavioral health needs, including substance use disorders (SUDs) and serious mental illness (SMI), face additional challenges accessing and managing behavioral healthcare services. Dual eligible individuals with behavioral health needs often have other complex needs, co-occurring conditions, health-related social needs (HRSNs),⁷ and/or require LTSS.

M. Ensuring Equitable Access – Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137)

CMS Proposal: CMS proposes at § 422.137(d)(6)(iii)(A) through (H) to revise the required metrics for the annual health equity analysis of the use of prior authorization.

SNP Alliance Response:

The SNP Alliance supports equitable delivery of services. However, we believe it is premature to expand the UM analysis at this point. Previous years' rules have not yet been implemented. UM Committees and health plans need time to work through the processes and approach from the previous policy around health equity analysis.

In order to support the intent and foster the utility of the analysis, we recommend that CMS develop guidance to set standards for a consistent approach for health plans on how to conduct a health equity analysis. Standardization also would greatly assist the UM Committees charged with conducting this analysis. The SNP Alliance feels as though guidance to support a standard, consistent approach across plans is necessary, especially if comparisons are to be made across plans.

Such foundational groundwork will guide UM Committee analysis, help the field work out gaps in methodology and interpretation, and demonstrate utility of the information. This groundwork will also allow the lay public to understand, follow, and correctly interpret results.

To facilitate understanding and further the intent, CMS is urged to consider contextual information around factors that are important when interpreting the data for analysis. There are many factors that impact prior authorizations, appeals, and denials. It is important to know the type of plan, characteristics of enrollees, involvement/contractual arrangements with providers, and other information, such as standards of practice of management and treatment within the local/regional area pertaining to specific conditions or diseases.

⁷ ATI Advisory, [Improving Behavioral Healthcare for Dual Eligible Individuals: Opportunities and Challenges](#)

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Special needs plans serve people with complex conditions and overlapping medical and psychosocial needs. These individuals have more providers and specialists involved in their care and, therefore, are likely to have more utilization and more claims per person. This would be expected in a high-need, complex population. Providers serving individuals with many complex conditions and social risk factors may need more time to consult with other specialists and coordinate on treatment and pharmaceutical management. This might take more time, resulting in some delays. Since each claim requires medical information from the provider and people with complex medical and behavioral health conditions often have multiple providers, a delay in authorization may be due to missing information.

Health plans with a higher proportion of individuals enrolled who have multiple and complex needs may report longer time to review claims as they have more data to review/analyze. The UM analysis would need to identify this contextual information. Comparing data across contracts, such as the number or rate of claims reviewed by population or the length of time taken to review the case, without this contextual information could lead to incorrect conclusions.

Therefore, in order to analyze or make comparisons across plans, CMS should recommend a structure and process for defining the data elements to describe the population and have the contextual information organized in a way that is done consistently.

In addition, to encourage improvement and effective use of the data, we recommend feedback be provided to health plans on findings. CMS is urged to compile an Annual Health Equity Analysis Report. An aggregate report such as this would provide the necessary information displaying key demographic profile information of the health plans' enrollment characteristics, such as percentage of enrollees who are dually-eligible, disabled, or low-income, the distribution of racial and language characteristics, age ranges, and percent of enrollees with three (3) or more chronic conditions, as well as the region served, characteristics of providers in the region, particularly if there are demonstrated access issues to primary care, specialty, or other providers, such as therapists. As stated, this background is crucial contextual information to understanding the analysis. We believe that such a CMS Annual Health Equity Analysis Report would be helpful to many stakeholders and would increase transparency around this policy. It would also offer a way to evaluate the effectiveness of the policy.

Regarding including “having a mental health or substance use disorder diagnosis” as indicative of a social risk factor, the SNP Alliance recommends caution. We are concerned that health plans may find themselves caught by privacy protections under State laws which are often more restrictive than federal HIPAA laws when mental or behavioral health conditions are involved. While this group is particularly important to monitor, UM committees include individuals from the community who are not licensed practitioners nor employees of the health plan. There may be a risk of PHI being exposed, and health plan may not know about the exposure or how to respond to such infractions. Our membership consists of many small health plans where PHI exposure could pertain to a recognized, identifiable member of the community. The SNP Alliance recommends obtaining additional guidance from subject matter experts and from states with restrictive privacy laws before including this group in the UM policy.

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Finally, feedback from health plans in the Alliance urge CMS to address the following:

- How privacy protections around mental health/substance use disorder should be managed to eliminate any risk of protected health information violations.
- Why quality improvement activities have been left out from CMS' definition.

N. Medicare Advantage Network Adequacy (§ 422.116)

CMS Proposal: CMS is proposing to codify longstanding policy language regarding network adequacy. Changes include:

- Codify policy of treating county equivalents the same as counties for network adequacy purposes
- Synthesize network adequacy exception request rationales and eliminate “provider does not contract with any organization or contracts exclusively with another organization” as a basis for an exception.
- CMS is proposing to eliminate the “other” category and eliminate the exception rationale of “provider does not contract with any organization,” as described above.
- Eliminate “provider has the potential to cause beneficiary harm” because this exception rationale is already covered under CMS’ evaluation of any exception, which includes ensuring the exception is in the best interest of the beneficiary as noted in §422.116(f)(2)(iii).
- Incorporate “the provider is not properly credentialed” exception under the proposed exception rationale of provider does not provide services for the specialty type listed in the Provider Supply file.

SNP Alliance Response:

There is no national standard for network adequacy,⁸ and standards that are applied vary significantly across states and types of coverage. Thus, the SNP Alliance understands that network adequacy is one of biggest challenges in Medicare Advantage. Despite minimum time and distance requirements crafted by CMS, in many instances provider networks are not sufficiently large or geographically accessible enough to meet the needs of beneficiaries. Limited availability, long travel distances, or a lack of specialists within the network leads to restricted access necessary care.

The SNP Alliance would like more information on the proposed changes. Each year network adequacy brings national attention, whether it is “ghost networks,” which refers to insurance networks that inaccurately or misleadingly list health care professionals in their directories for various reasons—they may not be accepting new patients or are no longer accepting that insurance—or beneficiaries are denied medically necessary care from an in-network provider. Network adequacy, in some aspect, has been discussed in the Final Rules for 2023 and 2024. With such a spotlight on network adequacy in Medicare Advantage, there is a need for CMS to codify and clarify the existing longstanding language.

⁸ The National Association of Insurance Commissioners developed a [Health Benefit Plan Network Access and Adequacy Model Act](#). However, it includes no quantitative standards, and adoption by states has been limited.

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The SNP Alliance would like more clarification on the plan benefit package (PBP) level network adequacy requirements. Currently, health plans often have SNP and non-SNP PBPs under the same contract. The entire contract satisfies CMS network requirement, but under this proposal at an individual plan level, SNP or non-SNP, a single PBP may not satisfy current network adequacy requirements due to CMS network adequacy time and distance standards. We ask CMS to only consider assessing network adequacy at the plan benefit package (PBP) level when there are differences in provider networks among PBPs within a contract. Many contracts include multiple PBPs, and assessing identical networks across PBPs would be inefficient and unnecessarily repetitive. This could have serious ramifications for hundreds, if not thousands of Medicare Advantage plans across the country.

In recent years, there has been a growing number of providers who decline contracting with MA plans or do “not contract with any organization or contracts exclusively with another organization.” Both of these rationales are impacting the care of Medicare beneficiaries. In the first instance, provider groups that are often located in rural counties are not choosing to contract due to the tremendous administrative effort and low member enrollment. The SNP Alliance requests that the CMS consider accepting rationale for provider groups that are willing to contract but decline due to administrative burden and low membership. The provider groups choose not to undergo the contracting process, even though collaboration and communication with the health plan was established.

In the second scenario, there are providers that do “not contract with any organization or contracts exclusively with another organization.” Currently, CMS allows MA plans to operate in geographic areas where a competing MA organization has ownership ties with a local provider. CMS wants to eliminate this rationale as a basis for an exception. Removing the exception may incent the MA organization with ties to local providers open small clinics visited by staff who will not contract with other MA organizations, thereby limiting member choice in that geographic area.

O. Promoting Informed Choice— Expand Agent and Broker Requirements regarding Medicare Savings Programs, Extra Help, and Medigap (§§ 422.2274 and 423.2274)

CMS Proposal: CMS is proposing to add requirements under §§ 422.2274(c)(12) and 423.2274(c)(12) for agents and brokers to discuss the rights and implications of switching from Medicare and Advantage to Traditional Medicare, the availability of low-income supports including the Part D Low-Income Subsidy (LIS) and Medicare Savings Programs (MSP), and/or existing resources for state programs that can help with health care costs. These proposed requirements will ensure that agents and brokers pause to address any enrollment questions before moving forward with the enrollment. CMS is also tackling formatting materials in more reader- and user-friendly.

SNP Alliance Response:

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The SNP Alliance applauds CMS’ continued efforts toward transparency and consumer-centric language to ensure that beneficiaries are well-informed of their options. Each year CMS makes incremental steps toward promoting informed choice.

However, the SNP Alliance is asking CMS to provide health plans with more clarity on the requirement for brokers to pause enrollment for questions. Without definitive, quantifiable language the pause requirement is very subjective—thirty seconds or eight minutes?

P. Format Medicare Advantage (MA) Organizations’ Provider Directories for Medicare Plan Finder (§§ 422.111 and 422.2265)

CMS Proposal: CMS proposes to make changes that will allow MA provider directories to be viewable on Medicare Plan Finder (MPF) for the 2026 Annual Enrollment Period (AEP). The intention is to improve the usability of Medicare Plan Finder, strengthen oversight of plan marketing materials, and require information sharing to ensure enrollees can make informed choices about their Medicare, Medicare Advantage, and Part D coverage. CMS proposes testing applicability for July 1, 2025.

Additionally, CMS is looking to clarify “direct furnishing entity.” Currently, it means any individual or entity that delivers or furnishes covered benefits to the enrollee. CMS is contemplating requiring direct furnishing entities (DFEs) to be included in the provider directory.

SNP Alliance Response:

The SNP Alliance has provided CMS with recommendations for updates and modifications to Medicare Plan Finder (MPF). We would encourage CMS to:

- Understand the administration complexities and additional operational burden that may occur if these provider directories are not in format that health plans currently use, like JSON formats.
- Verify whether provider types will be set up as cross-payer directories, otherwise it could be misleading to enrollees.
- Elect an attestation that the provider directory data first submitted for the MPF is accurate and consistent with CMS’ MA network adequacy requirements. Subsequently, a yearly attestation will be required.
- A 2027 plan year effective date, with a July 1, 2026, test date, instead of the proposed 2026 plan year effective date and July 1, 2025 test date. This would allow for additional development time if either FHIR APIs or machine-readable JSON files are selected as the option, especially since MA organizations will not have the final guidance until spring 2025.

The SNP appreciated CMS’ commitment to ensuring provider directories meet the needs of all beneficiaries. In addition to our recommendations above, we ask for file format alignment in Medicare Plan. If the file format aligns with existing standards such as the API Machine

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Readable Standards for the Marketplace, as outlined in the CMS Marketplace API Standards, implementation of provider directory information will be efficient and streamlined.

We also recommend that CMS provide clear guidance regarding the provider types that must be included in the directory. If the types of providers listed are not consistent across plans, the information could be misleading to enrollees. In addition, although we support this effort to provide useful information via Medicare Plan Finder, we believe that CMS must continue to seek solutions to the perennial challenges related to maintaining accurate provider directories. Despite ongoing efforts, inaccuracies persist. While plans actively work to address inaccuracies in provider directories through various initiatives, it is unrealistic to attest to complete accuracy at any given moment. The SNP Alliance encourages CMS to reconsider the attestation requirements. We recommend that CMS acknowledge these challenges and allow flexibility in the attestation process.

Our membership is concerned about providing details on direct furnishing entities in provider directories. As supplemental benefits, including non-primarily health related benefits, increase in health plans many beneficiaries receive services from direct furnishing entities. Benefits such as adult day care, transportation services, pest control services, or home modification services which construct ramps for homes are often completed by a myriad of contractors within a service area. The administrative burden to acquire, update, and maintain this information will be a difficult lift. Sustaining the quality of the information that would be available and provided to beneficiaries would be taxing on a health plan's operational feasibility.

We encourage CMS to collaborate with State and Federal partners and stakeholders to work towards development of a national provider directory to be leveraged across markets and programs. Such an approach would help ensure the accuracy of directories, as well as reduce the existing burden on providers and plans to maintain various directories using a patchwork approach.

Q. Promoting Informed Choice– Enhancing Review of Marketing & Communications (§§ 422.2260 and 423.2260)

CMS Proposal: CMS is proposing to expand the definition of materials considered to be marketing materials and eliminate two regulation tests for content standard, as described in §§ 422.2260(2) and 423.2260(2) of the marketing definition. This proposal takes communications materials and activities that meet the existing intent standard and shifts them to be considered marketing for purposes of CMS's MA and Part D marketing and communications regulations.

The intent of this proposed change would improve CMS oversight over the full scope of materials and activities that are intended to draw a beneficiary's attention. This proposal would enhance CMS's oversight of the marketing and communications materials and activities most likely to influence a beneficiary's enrollment decision.

SNP Alliance Response:

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At the SNP Alliance, 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. The quality of service starts with how beneficiaries learn about available health plans in their area.

Marketing and communications materials drive enrollment. In recent years, MA and Part D marketing and communications landscape has become increasingly competitive with health plans spending millions of dollars each year on enrollment campaigns. And, as CMS articulated in this NPRM, marketing misrepresentation complaints are growing with approximately 36,000 in 2023.⁹

The SNP Alliances would like CMS to understand that the addition of new types of materials subject to review will create timeline constraints for health plans and may cause problems for getting everything approved before Open Enrollment. We are concerned about the proposed broadening of the scope and definition of marketing materials. Expanding this definition would significantly increase the volume of materials requiring CMS review, creating an administrative burden for plans and overwhelming CMS with high review volumes within limited time frames.

One of largest challenges we foresee is how health plan organizations interpret “intent.” MA organizations, their downstream entities, and CMS may interpret the guidelines differently, leading to inconsistencies in how materials are treated. Subjectivity may lead to struggles and risks—meeting deadlines and compliance risks. Reclassification of communications materials or marketing activities may slow down the approval process of materials, lead to inconsistent submissions, and open the health plan up to potential compliance risks.

Another challenge we have heard of from our membership is marketing content with a dual purpose, or content that may be educational and influence retention. We ask CMS for more clarity on dual-purpose content and whether those materials fall under marketing regulations or not. Without clarity there are ramifications for both the health plans and CMS—more materials submitted to CMS that take up valuable review time or a decrease in educational content to assuage the fear they might unintentionally trigger marketing regulations.

With the incoming administration's focus on efficiency and reducing federal positions, delays in reviewing materials are likely. Such delays could hinder plans' ability to communicate critical information to members and prospective members in a timely manner, resulting in delays in care, misunderstanding of coverage, and challenges in selecting the most suitable plan. The SNP Alliance strongly urges CMS to maintain the existing definitions of communications and marketing to preserve clarity, avoid inefficiencies, and ensure timely communication with members and prospects.

T. Proposed Regulatory Changes to Medicare Advantage (MA) and Part D Medical Loss Ratio (MLR) Standards (§§ 422.2401, 422.2420, 422.2430, 422.2450, 422.2452, 422.2454, 422.2460,

⁹ CY 2026 NPRM

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422.2480, 422.2490, 423.2401, 423.2420, 423.2430, 423.2450, 423.2452, 423.2454, 423.2480, 423.2490)

CMS Proposal: Proposal looks to specify that only expenditures directly related to activities that improve health care quality may be included as quality improvement activity expenses in MLR numerator – thus excluding administrative expenses – similar to requirements for commercial MLR reporting. In the proposed rule, CMS would:

- Require provider incentives and bonus payments to be tied to clearly defined clinical or quality improvement standards,
- Prohibit the use of administrative dollars to be used with quality improvement activities
- Necessitate plans to submit information on provider payment arrangements.

In these sections, CMS is also proposing some condensed timelines that can be burdensome, especially for plans with fewer staff resources. For example, the proposal to establish standards for MA and Part D MLR audit examinations CMS specifies how to conduct MA and Part D MLR audit examinations and how to conduct the MLR desk review process. Specifically, at §§ 422.2450(a) and 423.2450(a), CMS proposed states that MA organizations and Part D sponsors would be given at least 15 calendar days advance notice of its intent to conduct an audit of an MA organization or Part D sponsor. Similarly, at paragraph (b) of §§ 422.2452 and 423.2452, CMS proposes to establish that MA organizations and Part D sponsors would have 15 calendar days from the date of issuance of the final audit report to request an appeal.

CMS also notes that it has concerns about the impact of vertical integration on the Medicare MLR. Concerns such as:

- Establishing parameters in MLR reporting that limit the amount of transfer payments between related parties included in the MLR numerator.
- Excluding profits earned by related parties in the MLR numerator.
- Revising the definition of incurred claims to include payments net of DIR paid by or to a Parent Organization (in addition to a Part D sponsor).
- Establishing a framework for assessing transfer payments made to or by related parties.
- Identifying information that would better define types of vertical integration or related party relationships.

SNP Alliance Response:

The SNP Alliance membership is concerned with some of the proposed parameters.

Provider Incentives and Bonus Payments

The change to require provider incentives and bonus payments be tied to clearly defined clinical or quality improvement standards has the potential for significant unintended consequences that could undermine the growth of value-based care in general. The SNP Alliance supports transparency and agrees that improved quality should be a requisite for financial success. However, we are concerned that increasing contractual and operational complexity will result in fewer organizations, payers and providers, offering and accepting value-based arrangements. We

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are also concerned that there will be a disproportionate impact and increased administrative burden for plans that care for the most complex and vulnerable populations.

The SNP Alliance urges CMS to continue to support flexibility as we collaborate with our partner providers to collaboratively improve healthcare outcomes efficiently. Additionally, we welcome the opportunity to engage in a more robust dialogue around efforts to capture best practices in this area and demonstrate the efficacy of value-based care arrangements.

Prohibit Use of Administrative Dollars to Be Used with Quality Improvement Activities.

The expansion of technology in healthcare and quality improvement increases complexity in identifying clear delineations in administrative expense and quality improvement expense. We urge CMS to lean toward flexibility with regard to this issue as well.

Necessitate Plans to Submit Information on Provider Payment Arrangements

The SNP Alliance believes this adds to the administrative burden and duplication of efforts as plans already are required to report this information to other entities within the State and Federal government. Bureaus of insurance in some states require disclosure of contractual arrangements, especially those involving provider risk.

Our questions for CMS to consider:

- Would the MLR also have such safety provisions previously required to related party profits?
- If the MLR is developed with different assumptions from the bids, then could the differing rules drive a required payment by simple nature of excluding some costs used in development of the bids?

While we understand CMS' goal of collecting more detailed information through the MLR calculations, some of the proposed parameters and exclusions could add difficulty for plans in meeting the 85 percent threshold, without associated benefits to the program or enrollees.

Reporting

The reporting requirements for the MLR report is expected includes aggregate expenditures by provider payment arrangement type in MA. The report submitted to CMS requests categories of provider payment arrangements ordered from lowest to highest financial accountability for providers: fee-for-service (FFS), Alternative Payment Models (APMs), and population-based payments. While the SNP Alliance appreciates the need to improve transparency and oversight certain payment arrangements, we would be remiss to mention that many of these provider arrangements are already included in Part C reporting requirements and as part of plan bids. Feedback and concern from our membership reiterates that the proposed provider payment arrangement reporting requirements are overly broad and would create an unnecessary administrative burden on plans. If CMS intends to finalize a new reporting requirement, the SNP Alliance asks CMS to review its tiering categories of provider payment arrangements and clarify why the existing information collected under the Part C reporting requirements and as part of plan bids is inadequate.

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Additionally, we urge CMS to revisit the advance notice for audits and appeals. The current regulation is at least 15 calendar days advance notice. We respectfully request CMS provide at least 30 calendar days to promulgate intent to conduct an audit and at least 30 days to appeal a remittance based on an audit finding.

Vertical Integration

Strong alignment of payer and provider is critical to driving improved outcomes especially for complex and vulnerable populations. Alignment can be achieved in various ways—through contracts or through operational alignment of provider and payer functions under the same parent organization. Because of the variation in payer and provider resources throughout the country, restrictions on related entity relationships may result in unintended consequences of less effective care delivery and increased cost. The SNP Alliance asks for clarification from CMS. It would be helpful to have more information to understand how alignment concerns can be addressed without negatively impacting the diverse solutions that are currently required to address gaps in healthcare services and payer/provider alignment.

U. Enhancing Rules on Internal Coverage Criteria § 422.101

CMS Proposal: CMS is proposing to build upon and enhance the regulations from the April 2023 final rule, specifically those related to the use of internal coverage criteria, by defining the phrase “internal coverage criteria,” establishing policy guardrails to preserve access to basic benefits, and adding more specific rules about publicly posting internal coverage criteria content on MA organization websites. Additionally, CMS proposes to add more structure and detail to the public accessibility requirements to ensure that MA organizations are making this information available in a manner that is consistent and easy to follow.

SNP Alliance Response:

The SNP Alliance is uneasy with the January 1, 2026, proposed date for displaying internal coverage criteria. This requirement asks for health plans to publicly display on their website a list of all items and services for which the plan uses internal coverage criteria when making medical necessity decisions. There are services, such as physical therapy, where the internal coverage criteria may be necessary without meeting a threshold requirement related to patient safety. We ask that CMS dictate a standard template with a specific format for the plan coverage criteria posted information assuring completion by the proposed date.

Section IV. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (§§ 422.166 and 423.186)

B. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)

CMS Proposal: In this proposed rule, CMS is proposing to add or update the following measures:

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- Initiation and Engagement of Substance Use Disorder Treatment (IET) (Part C)
- Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D)
- Breast Cancer Screening (Part C)
- Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C)

CMS is proposing to remove guardrails from the MA Star Rating methodology. Additionally, CMS is proposing to clarify at §§ 422.166(f)(3)(vi) and 423.186(f)(3)(vi) that in order for Institutional Special Needs Plan (I-SNP)-only contracts to have the rating-specific HEI calculated, these contracts must have data for at least half the measures included in the rating-specific HEI for the subset of measures that I-SNP-only contracts are required to report. In addition, CMS is proposing a clarification of how the improvement measure holds harmless for the highest rating is determined based on the rounded rating before the addition of the HEI reward.

SNP Alliance Response:

Guardrails—The SNP Alliance does not support removing the guardrails from the MA quality rating methodology. Guardrails protect from wide swings in cut points, and they have been very important in providing some stability in quality measurement. Recent history around MA Star Ratings has demonstrated the difficulty when methodological changes result in dramatic swings in measure-specific ratings or overall MA Star Ratings.

The recent volatile swings in cut points have impacted plans and their enrollees dramatically. This has resulted in having lower bonuses and fewer resources available for supplemental and other benefits, which particularly impacts people with high social risk issues. In addition, regarding quality improvement projects, these often require two to three years of sustained effort by the plan and provider to show effect. The health plan funds these quality improvement initiatives through expected future quality measure bonuses. When the cut points swing and the targets for performance are harder to reach, the bonuses are not forthcoming. This impacts the ability to continue to conduct the quality improvement project.

We strongly urge CMS to not only maintain the guardrail policy, but in fact to consider decreasing/lowering the guardrail range for an annual swing *from 5% to 3%* in order to provide greater stability in the measurement system as additional methodological changes are underway. Predictability is key to quality improvement and to support health plan operations planning, care management staffing, provider contracting arrangements, and other important decisions as they prepare for future years.

Measure: Initiation and Engagement of Substance Use Disorder Treatment (IET) (Part C)

Special needs plans with D-SNPs and FIDE-SNPs report struggling with this IET measure, especially on the initiation side of SUD—because by the time the plan receives the claim, the time frame for engagement has already passed. Furthermore, there are behavioral health shortages throughout the country and plans face this dearth of providers where appointments to address follow-up. Shortages of individual providers as well as of residential treatment, detox

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facilities, or opioid treatment programs, make access to care challenging for individuals in need of IET services. Quality improvement in these areas is dependent on addressing the ongoing, significant behavioral health provider shortage. The measure specifications and access issues both need to be examined. The IET measure is a composite measure that averages two separate rates: Initiation of Substance Use Disorder Treatment and Engagement of Substance Use Disorder Treatment.

The lack of ability to impact this process is particularly challenging for plans that do not own/control their own clinics or providers. Plans are trying to expand members' access to and acceptance of telephonic behavioral health, for telehealth visits, but people with high social risk issues face additional barriers to that kind of virtual care.

We urge CMS to consider options to modify this measure, such as lengthening the time frame between initiation and engagement, and/or recognizing the date for when there is a future appointment as evidence of intent of engagement. Evidence of intent for engagement should be considered even if it did not occur within the specified time frame due to lack of appointment availability. Similarly, if the individual participates in education about substance use disorder or has a visit with a peer advocate with intent to engage in treatment.

While we agree this is a critically important measure, IET is not appropriate as a plan measure as plans have no ability to identify a member with an index episode. Behavioral health services do not require prior authorization and a majority of the index episodes happen in outpatient settings. Given the time frames set forward in the measure, there is no plan ability to leverage traditional data sources (e.g., utilization management, claims, etc.) to support a member's ability to connect to substance use disorder treatment in the time frame of the measure. Health plans and providers may not have evidence of a prior diagnosis for individuals who have a previous diagnosis of substance use disorder but were enrolled in a different health plan or with a different provider—the health plan and provider may have no evidence of a prior diagnosis. Therefore, the diagnosis is not really “new.”

We specifically ask for this measure not to be moved to Stars Ratings for the 2028 Star Ratings (2026 measurement year). Given the barriers plans face with improving access to these services, the IET measure should exist as a provider performance-based measure only. However, should CMS decide to move forward with moving this measure to Star Ratings, we recommend addressing these barriers by (1) delaying the transition until underlying workforce issues are resolved and (2) moving the initiation measure alone to Star Ratings.

Measure: Reviewing Appeals Decisions

Plans request, when the coverage decision is appealed and overturned, that the reviewer provides written information on how the coverage decision was reviewed, and why it was overturned. These decisions do not come with enough information for the health plan to learn how to avoid making the same coverage decision in the future. This would help both the plan and the consumer to reduce denied and overturned coverage decisions.

Measures Applied to I-SNPs

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I-SNPs report challenges, particularly with the Part D measures, where medication adherence hinges on the facility providing the medication. I-SNPs do not always get a claim for medication services and that impact measurement scores. Additionally, the I-SNPs find challenges with the Breast Cancer Screening. The population may be younger than the cut-off age for the measure specifications but are frail or disabled and living in an institutional setting. Families and the members enrolled, who are living in the nursing facility, may not want to leave the facility to receive an annual mammogram.

Frailty Status

In addition, we recommend further attention to frailty considerations that impact how and when an individual will tolerate screenings and preventive care. The SNP Alliance appreciates the measure steward work to recognize this issue to date, but health plans and providers still report challenges with the “both/and” requirements around frailty and advanced illness criteria.

Display Measure Time frame

The policy is to place any proposed measure that has been thoroughly tested and validated on the Display page for at least two years prior to implementation and to move the measure back to Display when there are substantive changes. We suggest consideration that for some measures, there may need to be a longer “Display time frame.” For example, while the IET measure was developed some time ago and has previously been on the Display page, it has been a while since any testing or reporting was done with this measure. In that time need has grown and the scarcity of providers in some areas has worsened, making the time frames exceedingly difficult.

The SNP Alliance recommends that CMS direct the measure steward to conduct additional testing especially for Disabled/Dually Eligible/Low-income and those with high social risk issues populations and to consider environmental factors. We request that the results of testing on the feasibility of meeting this measure, as well as the realities of disparities in access to behavioral health in areas with neighborhood deprivation be published for plans and providers to understand the results prior to moving the measure to the Star ratings.

Considering Regional/Environmental Factors Impacting Measure Results

The SNP Alliances asks for further attention by CMS to urge measure stewards to examine regional and environmental factors that impact their measure result which are independent of plan action, such as a demonstrated lack of availability of providers (e.g., behavioral health, specialists). There may need to be a set of regional or environmental considerations put in place, similar to the disaster policy or policy around plans operating in Puerto Rico, where these characteristics impact the measure result independent of the plans’ action.

This may be an area for measure specification modification, specifically a population-level case mix adjustment in the measure scoring.

C. Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3))

I-SNPs and Health Equity Index

Special Needs ——— ——— Plan Alliance

The SNP Alliance thanks CMS for clarifying that I-SNPs would only be expected to have measurement data for at least half of the measures that are required for I-SNPs (as these types of plans are excluded from reporting on several measures). This change would allow I-SNPs to have access to the Health Equity Index. We appreciate this clarification.

Health Equity Index

Plans describe their difficulty in trying to replicate and forecast the Health Equity Index. They request more transparency and more information. Moreover, all other stakeholders are still without any information about the HEI simulations that have been conducted now for two years. CMS has these data and could summarize without too much difficulty.

This should be reported as soon as possible, and prior to implementation for Stars 2027. There are others with interest in this methodology, these data, and the results, such as advocates, policymakers, other governmental agencies, researchers, and the general public/taxpayers. We believe that plans should be given the information they need to replicate the results, and that the general public also has a right to the aggregate information. The SNP Alliance has identified a set of information that needs to be reported as soon as possible:

- The final measure set and weights for the 2027 HEI, based on MY 2024 and 2025 Star ratings selected measures. Data collection for 2025 is already underway and Measurement Year 2024 has concluded. It should be straightforward to provide the list of measures and the weights that will be used to create the composite index used in the HEI for Star Ratings 2027.
- The details on the methodology and regression analysis, so that health plans could replicate each step and confirm the results.
- The details on the tertile cut point thresholds for each measure and overall across the two years.
- Basic summary tables and graphs, with brief descriptions, from the first two years of simulation (which have already been performed by CMS but have not been released to the public). CMS has the data as the Agency already created and distributed MAO-specific reports in 2023 and 2024. CMS knows the number of contracts and the distribution of contracts, by measure and overall. In the interest of transparency and to provide information to assist plans in estimating potential HEI reward, we request these summary tables and summary graphs in a report to show:
 - The number of H# contracts that ***did not make the enrollment threshold*** each year for being considered eligible for the HEI based on ½ the median of enrollment that is dually eligible/disabled/low-income; and the total enrollment of these contracts.
 - The number of H# contracts that ***did make the enrollment threshold*** each year for being considered eligible for the HEI based on ½ the median of enrollment that is dually eligible/disabled/low-income; and the total enrollment of these contracts.
 - Of these, how many contracts are eligible only for half of the HEI reward?
 - Of the contracts included in the HEI eligibility cohort, the graphs, by measure and overall. Tables and graphs should show the Part C HEI included measures and Part D HEI included measures and then for overall. Such graphs showing the

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measure score distribution are important. This allows the reader to understand the shape of the distribution, such as if the measure score (of contracts included in the HEI eligibility “pool”) is unimodal, bimodal, or has another shape and where the tertile cut-offs are.

We wonder how many contracts did not meet the enrollment eligibility threshold despite having D-SNP, I-SNP, or C-SNP plan benefit packages contained within them? How many dually-eligible/disabled/low-income individuals are in contracts that will not be eligible to receive a Health Equity Index reward? These are important questions that need to be addressed.

In addition to needing more information and requesting transparency about the results of the two simulations to date, we have been hearing from our membership operating in states that require D-SNPs to move to separate contracts. The size of the D-SNP-only contracts are much smaller. A much smaller number of enrollees affects measure score distribution causing even a few outliers to impact the result. This leaves the smaller contracts in a more precarious position in terms of predictability of meeting measure score thresholds to achieve the HEI reward factor.

Finally, we note that the methodology for the HEI reward is set up to reward only the top third of contracts. We understand that there may be adjustments in the methodology over time. The SNP Alliance requests CMS consider what can be done to reach more contracts in order to provide additional resources to reach more people who are at risk.

Improvement Measure

We recommend that the Improvement Measure calculation be performed AFTER the Health Equity Index reward factor is applied, in order to provide recognition of the efforts/performance of those plans serving a high proportion of dually eligible/disabled/low-income individuals where they have achieved performance in the top third tertile, as compared to peer plans.

Section V. Improving Experiences for Dually Eligible Enrollees

A. Member ID Cards, Health Risk Assessments, and Individualized Care Plans (§§ 422.101, 422.107, 422.2267, 423.2267)

Dual eligible beneficiaries are often faced with fragmented care. Enrollment in two government programs can mean that care can be misaligned, confusing, or duplicative. For years, federal regulations have been weaving together and simplifying these two programs for dual eligibles. Integrated care is the approach to deliver coordination and payment of Medicare and Medicaid services. With this proposal from CMS, the efforts focus on integrating positive learnings from the financial alignment initiative (FAI) or MMP demonstration, amend the requirements related to HRAs and individualized care plans (ICPs) for all SNPs, and refining tools, tasks, and opportunities to enhance the dual eligible enrollee’s experience.

One of our values at the SNP Alliance is to ensure that individuals with significant, complex needs have the knowledge, access, and choice to select services that address their unique care

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needs. We aim to reflect those values in our commitment to integrated care for the dual eligible population.

CMS proposes several changes to advance integrated care for dual eligibles. We believe that dual-eligible individuals can benefit greatly from increased integration and smart integration. We appreciate the work done by CMS and others to advance integrated policy to move toward a seamless experience for the enrollee. Our comments are meant to continue to advance this goal with considering the impact on the enrollee first, and also working to make the programs efficient, effective, and streamlined in terms of administrative burden.

a. Integrating Member ID Cards for Dually Eligible Enrollees in Certain Integrated D-SNPs

CMS Proposal: CMS proposes a requirement that Applicable Integrated Plans (AIPs) provide enrollees one integrated member ID card for both the Medicare and Medicaid plans in which members are enrolled. Content for cards must meet existing applicable Medicare and Medicaid requirements effective October 1, 2026 for contract year 2027.

SNP Alliance Response:

The SNP Alliance has a long-standing position supporting this key integration provision for plans with aligned enrollment. We support CMS' continued effort to integrate materials for dually eligible enrollees by furnishing one integrated member ID card to serve as the ID card for both the Medicare and Medicaid plans in which the enrollee is enrolled. This provision would impact applicable integrated plans (AIPs) in three states—Washington, New York, and Puerto Rico. The SNP Alliance expects to see more states move to one integrated ID care in the states transitioning from MMPs to D-SNPs in 2026. The MMP states already require integrated ID cards.

The SNP Alliance requests that CMS consider defining a standard framework for an integrated ID card applicable to all AIPs. Currently, every state is approaching it in their own way. That variety complicates the design and the amount of information that needs to fit on the card. We suggest that CMS craft a universal template that all health plans can use to ensure that all the vital information is on the integrated ID card.

We request this guidance be published to ensure that integrated ID cards do not become fragmented and administratively burdensome with varying requirements across states. The SNP Alliance agrees with CMS that extending this requirement to HIDE-SNPs, or non-aligned D-SNP beneficiaries who do not have exclusively aligned enrollment, would be burdensome given the lack of consistency in aligned membership and cause significant operational challenges.

b. Integrating Health Risk Assessments for Dually Eligible Enrollees in Certain Integrated DSNPs

CMS Proposal: Require D-SNPs that are AIPs to conduct a comprehensive HRA that meets all requirements as well as any applicable Medicaid requirements, such that enrollees in the AIP complete a single integrated HRA for Medicare and Medicaid.

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CMS is proposing only D-SNPs that are AIPs to meet this new requirement. CMS believes it is feasible for D-SNPs whose enrollees are exclusively aligned with an affiliated Medicaid MCO to implement a fully integrated HRA. Beginning in 2025 all FIDE SNPs are AIPs and so this proposal encompasses all FIDE SNPs.

CMS proposes to specify that SNPs conduct the comprehensive initial HRA within 90 days (before or after) of the effective date of enrollment for all new enrollees in order to better align with the Medicaid requirement at § 438.208(b)(3) and, for Medicare, conform to § 422.112(b)(4)(i) and the standard currently described for reporting HRA completion in the Part C Reporting Requirements.

SNP Alliance Response:

The SNP Alliance is encouraged by CMS' continued pursuit of integration for dual eligible special needs plan beneficiaries. The SNP Alliance wants the integrated HRA to be implemented as successfully as possible within states.

We appreciate CMS' efforts to reduce burden and duplication for dually eligible individuals. If CMS requires adoption of a single integrated HRA for AIPs, we encourage the agency to simultaneously offer technical assistance and training to states and MCOs to: 1) help clarify what specifically will be required within the integrated HRA and; 2) create a common framework for doing so across all states, since the application of an integrated HRA could otherwise look different in every state, which would be operationally challenging.

The core operational challenge acknowledged in the proposed rule is in relation to the different enrollment time frames and effective dates of Medicare and Medicaid members. Though the proposed rule "would not change any specific Medicare or Medicaid requirements for the timing of or elements included in an HRA." But to achieve an integrated HRA the requirements for timing would need to change to support that alignment. We also recommend CMS encourage states to align Medicaid and Medicare enrollment timelines for dual eligible individuals to avoid beneficiary confusion and disruption of benefits or services such as a universal timeline to complete a HRA and ICP to remove any room for confusion and prevent gaps.

We also appreciate CMS's proposed allowance that plans combine only the initial base level assessment so that members do not need to complete all potential components of the assessment in one sitting, which could take hours. We encourage CMS to work towards standardizing HRA instruments and the questions they contain more broadly so that Medicaid or Medicare instruments can be used interchangeably. The time needed to develop the appropriate integrated HRA that is streamlined and has the appropriate level of standardization to assess core clinical and social needs will be lengthy. We recommend deferring implementation of this requirement to allow for additional time to work through the complexities and the state Medicaid programs HRA instrument redesigns to eliminate overlap with Medicare requirements. The HRA should be easy, user friendly, and not be a burden.

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The SNP Alliance supports CMS' proposal to only require D-SNPs that are exclusively aligned AIPs to implement integrated HRAs. This proposed requirement is too operationally complex for HIDE SNPs or all D-SNPs at this juncture.

c. Promoting Person-centeredness in SNP ICPs and Timeliness of HRAs and ICPs and d. Opportunities for Improvement

CMS Proposal: CMS is proposing to codify timeliness standards via amendments to § 422.101(f)(1). The proposal plans to improve the arrangement of various HRA and Integrated Care Plan (ICP) requirements and strengthen these requirements. CMS proposes that meets HRAs all requirements at § 422.101(f)(1)(i) through (v) as well as any applicable Medicaid requirements, including those at § 438.208, such that enrollees in the AIP complete a single integrated HRA for Medicare and Medicaid.

CMS also raises the question of whether this requirement should be applied to all HIDE SNPs and asks for suggestions as to whether application to a different subset of D-SNPs should be proposed in future rulemaking.

The proposal highlights several person-centered additions, including:

- Conduct the comprehensive initial HRA within 90 days (before or after) of the effective date of enrollment for all new enrollees.
- Require SNPs to use a comprehensive risk assessment tool that CMS may review during oversight activities that assesses the enrollee's physical, psychosocial, and functional needs and includes one or more questions from a list of screening instruments non-health related social needs such as housing stability, food security, and access to transportation.
- Establish specific outreach requirements regarding completion of the HRA. These specifics include at least three non-automated phone call attempts, varying the days and times of the day of the contact, and a follow-up letter to complete the HRA.
- Address HRA results into the beneficiary's ICP.
- Develop an ICP within 30 days that reflects person-centered goals and objectives, updated as warranted with changes in health status or care transitions of enrollees.

SNP Alliance Response:

We agree with and support the effort and intent to align policy and practice around Medicare and Medicaid for dually eligible individuals and to reduce burden on the enrollee. The SNP Alliance recommends that CMS create a common health risk assessment that would be the core HRA with specific standardized elements across all states. Common minimum requirements across states would greatly enhance integration efforts and build the ability to create benchmarks, assess performance, and capture best practices.

The proposed policy pertains to many aspects of the care coordination processes, including health risk assessment, social risk screening, individualized care plan, care management, goal-setting, and interdisciplinary care team requirements and activities. CMS has an important role and opportunity to provide information, guidance, and resources to states and health plans as we collectively build the "on-ramp" toward complete alignment. There are capacity and knowledge-

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building steps needed now in order foster effective integration strategies and achieve efficiencies from an operational standpoint for health plans, states, the federal government, and beneficiaries.

Moving ahead, we do see some challenges for D-SNPs. CMS may wish to slightly modify the policy language and may wish to qualify where CMS can work with States to provide further information and guidance to health plans that operate D-SNPs. In considering the challenges that might arise, the SNP Alliance contemplated some options to address these challenges:

Deemed Status – One idea to foster this knowledge-building is to have either the federal or state agency grant temporary deemed status for compliance. There would be great value and utility in having states adopt the federal Model of Care (MOC) requirements as these are standardized and well-established in the field. D-SNPs already follow these requirements. The NCQA, acting under contract CMS already reviews all of these functions of D-SNPs through a comprehensive written Model of Care that is then subject to CMS oversight and audit. This would be the most straightforward way to align and integrate these care management activities. As states become more familiar with federal Model of Care requirements, adopting this “Federal Deemed status” option might welcome the assurances that come from having a standard set of guidelines, oversight, and enforcement of these care management activities and processes. We urge CMS to work with states to consider this “Federal MOC = Deemed Status for State.”

However, we realize there may be some states where state-specific requirements around the content, timelines or processes are already in contract and do not sync/align with Medicare requirements and specifications as outlined in the Medicare federal Model of Care standards. These states may need some time to modify their requirements or may not be able to adopt the federal standards due to state legislative language or policy governing Medicaid.

As states consider how to modify their health risk assessment, social risk screening, individualized care plan, or interdisciplinary care team requirements to align with federal Model of Care guidelines, perhaps CMS can provide deemed status on a temporary basis for D-SNPs/AIPs that meet all of the State care management requirements as a substitute for the federal MOC requirements.

On a temporary basis this would provide health plans with deemed status as meeting the Model of Care requirements, where the state has requirements around HRA, ICP, and ICT that are different than the care coordination standards specified in the federal MOC guidelines but align with the federal statutory language. In this alternative option--“State MOC = Deemed status approval by NCQA/CMS” would be extended to D-SNPs that are under contract with the State to have those sections/elements of the MOC considered as meeting federal MOC requirements as long as the D-SNP meets the State standards. This temporary option allows states and plans to build their knowledge, acumen, infrastructure, and practices around integrating the Medicare and state-specific Medicaid care coordination requirements.

State to Federal Crosswalk – At a minimum, absent deemed status, we urge CMS to work with states to *create a comprehensive crosswalk document* showing each state’s requirements and policy around health risk assessment, social risk screening, care planning/ICP, care management,

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and care teams (ICT), as well as oversight activities by the state to review these care coordination elements. Each component compared to the federal Model of Care requirements. This would help everyone see where these requirements are the same/similar, or where minor or more substantive differences occur. In addition to the content of these care management functions, the SNP Alliance would like to note that there are differences in administrative procedures, time frames, and approval cycles. These could also be included in the crosswalk showing each State and the federal MOC standards.

Proposals Pertaining to Specific MOC/Care Coordination Actions

Health Risk Assessment & Individualized Care Plan Timing– We urge CMS to adopt the longer time frame for conducting the HRA and subsequent development and implementation of the ICP. We recommend a standard 90-day time frame for the HRA and an additional 60 days for the ICP, to provide for administrative and procedural issues and recognize that plans must coordinate with the Medicaid enrollment and eligibility dates when reaching out to individuals to encourage them to participate in a health risk assessment and individualized care planning.

Requirement for ICP When the Member Cannot Be Reached - Real challenges arise when individuals are difficult to reach or refuse the HRA and do not respond to subsequent contacts. Plans continue to struggle with the issue of enrollees who are unable to be reached or decline to participate in the HRA and ICP processes. This is a frequent issue. Therefore, we agree with CMS that there should not be a federal requirement for an ICP in these cases. To align with state and federal interest in having every enrollee participate in an ICP, we offer a possible option. When and if these individuals are finally open to the HRA and ICP process, this date could be noted by the health plan. Then the clock could start ticking for HRA and ICP completion (this would override the enrollment date). To allow for sufficient time for the individuals to participate in care planning in a meaningful way, the time frame from the date of enrollee agreement to completion of the health risk assessment could be 90 days, with an additional 60 days for working with the member to create an individualized care plan, to be consistent with the other time frames proposed. We believe that this would support the intent for health risk assessment, care planning and meaningful member engagement, while recognizing the right for individuals to have agency around their own lives and make their own decisions about when and with whom they share personal health information.

We urge states to try to encourage enrollee participation in HRAs and ICPs at time of Medicaid eligibility enrollment and annually thereafter. We welcome information from states on best practices and strategies that state agencies have used about how they encourage dually eligible enrollees to participate in the HRA and ICP processes performed by their health plans. There may also be best practices and methods by primary care providers, counties case managers, or others--such as text messaging or electronic surveys--that have been successfully deployed to conduct the HRA or get input on an ICP. We recommend that CMS maintain a repository that shares this kind of information with the field.

Person-Centered Planning and Goal-Setting – The SNP Alliance appreciates the interest in and support for person-centered care planning. We note that several SNPs are participating in an

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effort by NCQA to develop and test person-centered outcome measures and determine the feasibility, accuracy, and utility of such measures. Such measures are several years from being ready.

However, we suggest that more work be done before implementing requirements around “person-centered planning.” The SNP Alliance recommends that the various definitions of this term be documented first and that these definitions be connected to how person-centered planning is put into practice in various settings and for various population groups. An examination of real-world implementation would greatly inform the policy and regulatory language. There may be differences in staffing/training, processes, operational guidelines, and enrollee engagement by type of population. For example, person-centered planning with frail elderly individuals living in a nursing facility may be quite different than when working with young physically disabled people living in the community and who are employed part-time. This is important foundational knowledge that should guide policy development.

d. Assuring Enrollee Advisory Committee Input on MOC Updates

CMS Proposal: In the May 2022 final rule, CMS codified the requirement at § 422.107(f) that D-SNPs establish or maintain one or more enrollee advisory committees (EACs) that serve the D-SNPs offered by the MA organization in a State. In this proposal, CMS is considering adding language to D-SNP EAC requirements at § 422.107(f) to include updates to MOCs as described at § 422.101(f). This addition would make model of care (MOC) updates an essential topic in every EAC meeting. The rationale for adding these topics to the D-SNP EAC conversations would ensure MA organizations solicit feedback directly from enrollees to improve the care coordination process including HRAs and ICPs as described in the MOC. This would not involve or require EACs to review the lengthy, technical Model of Care documents.

SNP Alliance Response:

The SNP Alliance supports the intent in having dually eligible enrollee perspectives around key care coordination elements, such as health risk assessments and individualized care planning which are essential components of the Model of Care. Such input could be included as part of the EAC topics for discussion over the course of the calendar year. If there are specific issues or areas CMS believes must be covered, that information should be relayed to plans.

We believe that plans’ EACs should be able to use discretion in including MOC-related topics in the EAC meeting agenda. The committees may structure the discussion to the appropriate competency level to improve health literacy and drive further discussions that can improve the overall D-SNP programs. This is a practice that SNPs report already doing on such topics.

However, we caution that CMS does not mandate MOC-specific review, nor the timing or format for these discussions. Each plan and EAC may want to combine a focus on these topics with other related efforts, such as around quality improvement or member engagement discussions.

We agree with CMS not to place a burden on the EAC or the plan for an actual review of the MOC document, given the length, technical details in the Model of Care document and the very

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short turnaround that plans have (a few months) to develop or revise these documents to meet requirements. The MOC scoring guidelines are released mid to end of November each year and the fully finished MOC document must be uploaded to the HPMS system by mid-February. Given the extensive input needed from different subject matter experts and departments within the plan--e.g., clinical services, quality, member services, provider contracting, population health, data analytics—to develop, coordinate, and write the MOC, it would be nearly impossible for the EAC to be able to review and provide direct input into the document in that time frame. Furthermore, this is outside of the scope of EACs.

e. Comment Solicitation – Making State Medicaid Agency Contracts Public

CMS Proposal: Section 164 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1859(f) of the Act to require that a D-SNP contract with the State Medicaid agency in each State in which the D-SNP operates. State Medicaid Agency Contracts (SMACs) are integral components for the successful delivery of integrated Medicare and Medicaid services.

CMS reviews all the SMACs for compliance but has never required SMACs to be publicly shared.

SNP Alliance Response:

The SNP Alliance has approached CMS in recent months about the need for transparency on the important requirements housed with the SMACs. We know that the provisions in the SMAC are of significant public policy interest. The SNP Alliance wholeheartedly encourages CMS to post the contents of the SMACs online.

Consider the June MACPAC report which focuses optimizing SMACs.¹⁰ More states are leveraging their contracting authority, but state adoption of SMAC provisions is uneven. The MACPAC report details the opportunities for CMS to promote accountability and for states to identify promising practices to implement in their SMACs. We believe a CMS requirement for all states to share their SMACs to a publicly available website would be beneficial to everyone—states, advocates, researchers, etc.

B. Clarifying Highly Integrated Dual Eligible Special Needs Plan Definition Relative to Oregon’s Coordinated Care Organization Structure (§ 422.2)

CMS Proposal: CMS proposes a narrow change in the HIDE SNP definition to allow scenarios in which there is a capitated contract between the State Medicaid agency and a local nonprofit public benefit corporation of which the MA organization is a founding member to be considered HIDE SNPs. This proposal is based Oregon where the current parent organization where similar entities owned and controlled by the MA organization’s parent organization as included in paragraph(1)(ii) of the HIDE SNP definition.

¹⁰ [MACPAC June 2024 Chapter 2 Optimizing State Medicaid Agency Contracts](#)

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SNP Alliance Response:

The SNP Alliance supports this narrow change in the HIDE SNP definition. We have membership in Oregon, and we support the technical changes in this proposal. At the SNP Alliance, we work with health plans to meet them where they are on their integration journey. The runway toward integration needs as flexible for states.