National
MLTSS
Health Plan Association

August 31, 2022
Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4203-NC
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure:

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on CMS' Request for Information (RFI) on the Medicare Advantage (MA) program, published in the Federal Register on August 1, 2022.[1]

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and take risk for long-term services and supports (LTSS) provided under Medicaid.[2] Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Our members currently cover a large majority of all enrollees in MLTSS plans and integrated plans, including national plans and regional and community-based plans.

The MA program is a critical provider of health coverage to the MLTSS population and MA plans of all types are essential partners in assisting with the effective management of LTSS. More than seventy-five percent of Medicaid LTSS beneficiaries are dually eligible for both Medicare and Medicaid. Dually eligible beneficiaries make up twenty percent of Medicare and fifteen percent of Medicaid enrollees but one-third of the cost in both programs. Notably, less than ten percent of full-benefit dually eligible beneficiaries are enrolled in programs that integrate Medicare and Medicaid.

Given the significant overlap in populations between MLTSS plans and Medicare, the MLTSS Association has long supported the MA program and the vital role that it plays in the care for so many LTSS beneficiaries. The MLTSS Association has focused on supporting and developing polices that better integrate the

[1] Medicare Program; Request for Information on Medicare. 87 Fed. Reg. 46918. August 1, 2022. Available at: https://www.govinfo.gov/content/pkg/FR-2022-08-01/pdf/2022-16463.pdf
[2] Members include Aetna, AmeriHealth Caritas, Anthem, CareSource, Centene Corporation, Commonwealth Care Alliance, Inclusa, LA Care Health Plan, Molina Healthcare, UPMC Community HealthChoices, and VNSNY CHOICE Health Plans.

Medicare and Medicaid programs with a particular interest in policies related to Dual Eligible Special Needs Plans (D-SNPs), which are currently the primary source of integrated care to dually eligible beneficiaries. To that end, the MLTSS Association has developed a set of policy proposals to advance integrated care that we have shared with both Administrative and Legislative staff.

It is with this unique interest in polices related to integration of services for dually eligible beneficiaries – with specific attention to D-SNP related policies – that we provide the following comments on the MA RFI. Generally, our responses include the following themes:

1) The MA program is a critical delivery system of care not just to nearly fifty percent of Medicare beneficiaries, but to a large portion of dually eligible beneficiaries. The MLTSS Association strongly supports policies that bolster the MA program and ensure it continues to provide tailored, innovative, and cost-effective Medicare services to beneficiaries across the country.

2) D-SNPs are unique plan types within the broader MA program that are also the most prominent delivery system of integrated care for dually eligible beneficiaries. In comparison with non-SNP MA plans, D-SNPs face a more nuanced regulatory environment and a more medically complex beneficiary population. CMS should closely consider the unintended impacts that any broad changes to MA policies may have on D-SNPs and the populations they serve.

3) Many elements of the broader MA program apply differently to D-SNP plans than to non-SNP MA plans. This is particularly true in policies related to marketing, data sharing, Star Ratings, supplemental benefits, and rate setting. We encourage CMS to set policies that account for these differences to ensure that D-SNPs are best positioned to meet the needs of their beneficiaries. While we recognize that such policies would increase resources for D-SNPs, we believe that such changes can be done without raining the overall costs of the Medicare program.

4) We commend CMS' recent attention on advancing the integration of the Medicare and Medicaid programs. The MLTSS Association recommends several ways in which CMS can continue to achieve a more aligned and connected D-SNP delivery system.

Our specific responses are outlined below.

Advance Health Equity

A.1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life?

Access to a robust direct care workforce is critical to ensure enrollees with disabilities, frailty, and other serious health conditions receive the care that they need. However, significant shortages persist in direct

care workforce availability, that have only been exacerbated by the COVID-19 pandemic.[3] To alleviate workforce shortages, the MLTSS Association recommends CMS consider several strategies in conjunction with state Medicaid programs:

1. Ensure direct care workers and front-line supervisors have opportunities for needed training, mentoring, and professional development.

2. Provide credentialing opportunities, career pathways, and ongoing competency-based training and mentoring to create incentives for direct care worker participation. Encourage the development of statewide career advancement pathways for direct care workers based on the completion and demonstration of CMS' core competencies, with career lattices (with corresponding increased wages) for individuals who have been deemed by a neutral third-party as proficient in demonstrating competency areas.

3. Ensure direct care works reflect the racial and ethnic diversity of the beneficiaries that they serve.

While these policy recommendations exist outside the scope of typical MA policy change, we highlight them here to underscore the broader reality of equity-related elements impacting the dually eligible population and to encourage CMS to adopt a holistic view when setting policies that impact dually eligible beneficiaries. We ask that CMS ensure that any policies considered as a consequence of this (and other) comment solicitations are carefully assessed for the impact they may have on programs serving dually eligible beneficiaries.

Moreover, these recommendations do intersect with MA policy in the context of supplemental benefits – particularly in the practice of integrated D-SNPs using supplemental benefits as a wrap around and/or complement to existing Medicaid services (e.g., offering additional limited personal care services in a way that is informed by state-specific HCBS coverage). We discuss our policy recommendations with respect to MA supplemental benefits in response to question B.7.

We also believe that the D-SNP program is uniquely situated to address the health equity goals of the Biden Administration. The dually eligible population is 62% female (compared to 53% Medicare only), 30% black or Hispanic (as compared to 10% Medicare-only), and 75% live under the federal poverty level (compared to 11% Medicare-only).[4] Policies that promote integrated care, including policies that strengthen the D-SNP program, also support equitable access to care.

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[3] Kaiser Family Foundation. Direct Care Workforce Shortages Have Worsened in Many States During the Pandemic, Hampering Providers of Home and Community-Based Services. August, 2021. Available at: https://www.kff.org/coronavirus-covid-19/press-release/direct-care-workforce-shortages-have-worsened-in-many-states-during-the-pandemic-hampering-providers-of-home-and-community-based-services/#:~:text=During%20the%20pandemic%20many%20states,and%20the%20District%20of%20Columbia

[4] ATI Advisory. A Profile of Medicare-Medicaid Dual Beneficiaries. June 2022. Available at: https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf

Finally, the 2023 Part C and D Final Rule included a new requirement for MA organizations offering D-SNPs in a state to establish and maintain at least one enrollee advisory committee to solicit direct input on enrollee experiences. The MLTSS Association supports incorporating the perspective of beneficiaries into plan structures to ensure that plans are providing the services that members need. We also encourage CMS to continue to allow plans broad flexibility in the development of enrollee advisory committees to best reflect the type of D-SNP models currently in place and the complexity of the dually eligible populations served.

A.9. How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPSs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?

As outlined in our Integrated Policy Proposals, the MLTSS Association supports a number of enhancements to advance the D-SNP integrated care landscape:[5]

- **Create a new special enrollment period for dually eligible beneficiaries in Original Medicare to enroll in an integrated care product (D-SNP or MMP) on a continuous (monthly) basis**. Once dually eligible beneficiaries are enrolled in a program, they cannot switch between D-SNP/MMP products outside of existing enrollment timelines. This is not intended to change existing enrollment timelines for those already enrolled.
- **Expand default enrollment authority beyond newly eligible beneficiaries to all dually eligible beneficiaries in Original Medicare enrolled in the parent company's managed care organization with an option to opt-out**. Highly Integrated D-SNPs (HIDE-SNPs) and Fully Integrated D-SNPs (FIDE-SNPs) which meet current requirements for performance indicators (i.e., 3 star rating and above, or no star rating if the plan is new/has low enrollment) would be eligible to default enroll dual-eligible beneficiaries into the HIDE-SNP or FIDE-SNP if the beneficiary is enrolled in Original Medicare and in the HIDE/FIDE's parent company's Medicaid managed care organization. Moreover, the expanded authority would apply to any HIDE-SNP and FIDE-SNP entities that have a Medicaid contract which covers, at minimum, a comprehensive set of LTSS as well as home and community-based services with reasonable state-specified service exclusions and carve-outs.
- **Provide MMCO with funding to establish a grant program for states to build their capacity to design/implement integrated care programs**. MMCO would be responsible for creating a grant program for states who wish to apply for a one-time planning grant to perform a certain set of activities (e.g., hiring new administrative staff with Medicaid and Medicare knowledge; building integrated IT infrastructures to connect with CMS', health plans', and providers' information systems) related to improving integrated care for existing or future improvements to integrated care programs. States receiving grant funding would be required to implement a training for state employees on the dually eligible population and integrated care programs.

[5]The National MLTSS Health Plan Association. Policy Proposals to Advance Integrated Care. July, 2021. Available at: https://www.mltss.org/post/the-national-mltss-health-plan-association-s-policy-proposals-to-advance-integrated-care-1

- Expand MMCO's authority of integrated care products. Authority over all integrated products would be permanently transferred from CMMI to MMCO. MMCO would have greater oversight and ability to make modifications to integrated care programs compared to current limitations in areas such as enrollment, marketing, grievances, appeals, and technical assistance (e.g., regular check-in meetings with MMCO, plans, and states). Any enhanced oversight should seek to simplify administration and streamline regulatory reporting.

B.1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

The MA programs serves nearly 50% of all Medicare enrollees and represents the main form of integrated care for dually eligible beneficiaries. MA plans have put significant effort into ensuring that beneficiaries are able to readily navigate the plan and benefit selection process. The need for this navigation is particularly important for integrated care products, which benefit particularly vulnerable populations but can have more complex benefit packages that are not easily communicated to potential or current enrollees (*see our discussion of this concept in the response to question B.8 below*).

The MLTSS Association recommends CMS, MMCO, and ACL, in collaboration with states and other stakeholders, develop national educational materials outlining the benefits of integrated care. The goal of these materials would be to increase beneficiary, provider, State Health Insurance Assistance Programs (SHIP and other counseling entities), and MA broker awareness and knowledge of integrated care products, including D-SNPs. These materials should translate the responsibility placed on D-SNPs to more holistically manage the care of dually eligible beneficiaries (e.g., HIDE-SNP and FIDE-SNP integration requirements) as well as outline the tailored supplemental benefits provided to the population. A good reference point for such tools is Minnesota's SHIP counselor materials, which outline annually the changes to supplemental benefits across all plan types, including D-SNPs, allowing counselors to better guide beneficiary plan selection.

In addition, the MLTSS Association recommends the development of a one-time grant program for states, in partnership with the SHIP TA Center, that would create training modules for SHIP counselors and other state-specific education materials for Area Agencies on Aging (AAAs), beneficiaries, primary care providers, MA brokers, and other community stakeholders. The training grant would support staff time spent developing these materials, educating relevant entities on integrated care products and managed care in general, facilitating greater coordination between SHIP programs and Medicaid agencies within states, customizing materials by region, and other related activities.

Finally, the MLTSS Association recommends CMS update the Medicare Plan Finder (MPF) to include new functionality and information on integrated care products. This includes the ability to show comprehensive summaries of available supplemental benefits to support transparency, inform beneficiaries' plan choice,

and empower beneficiaries to fully take advantage of new benefits. We also recommend CMS review the accuracy of how Special Supplemental Benefits for the Chronically Ill (SSBCI) and Value-Based Insurance Design (VBID) benefits appear on MPF and other sites that pull from Medicare.gov. We also recommend CMS conduct ongoing working sessions with health plans to assist with creating and testing web-based versions of the software. The MPF should be able to identify integrated plans, their level of integration, the types of tailored benefits the plan offers to the dually eligible population, and outline high-level general information on the benefits and advantages of integrated care products. All of these materials should be developed in a beneficiary-friendly fashion with the input of the advocate and consumer community in order to ensure they are accessible, usable, relatable, and relevant to the needs of dually eligible beneficiaries.

B.3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

The value proposition of integrated products – particularly integrated D-SNPs – can be difficult to communicate to beneficiaries and their advocates. The complex regulatory environment, coupled with correspondingly complex policy solutions, do not lend themselves to an easy distillation of information needed to inform the beneficiary plan selection process.

CMS should recognize the barriers of communicating on the unique benefits of D-SNPs to beneficiaries over other MA products and work with stakeholders to develop tailored communication tools that successfully outline the value of integrated products. For example, CMS can include additional information on the benefits of D-SNPs within the Medicare and You Handbook.[6] As previously stated, CMS can also update the Medicare Plan Finder to include information on integrated care products. CMS should also consider developing materials targeting caregivers and guardians, who often make health coverage decisions on behalf of the beneficiary.

MA plans attempt to solution for this barrier by developing D-SNP-specific education materials on their websites and printed mail. These materials are intended to educate beneficiaries, providers, advocates, and representatives on the unique and tailored benefits that D-SNPs offer and how D-SNPs differ from non-SNP MA plans. We recommend CMS create similar materials in broker training programs as a means of further propagating the value of integrated delivery systems.

[6] Centers for Medicare and Medicaid Services. Medicare & You 2022: The official U.S. government Medicare handbook. September, 2021. Available at: https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf

B.4. How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

The MLTSS Association has previously advocated for the consideration of LTSS needs in advancing behavioral health care and integrated care initiatives, including the anticipated Congressional mental health package.[7] Behavioral health, LTSS, and integrated care are inextricably linked – Three-quarters of LTSS users are dually eligible individuals, and 41% of dually eligible individuals have at least one mental health diagnosis. The dually eligible population is particularly high-risk and high-cost due to the complex intersection of medical and socioeconomic factors as well as the convoluted patchwork between the two programs.

Consequently, there is great value in ensuring D-SNPs can provide whole-person care to beneficiaries, including their physical, behavioral, and long-term care, and social needs. As such, the MLTSS Association supports state efforts to carve-in behavioral health care services and LTSS into MCO contracts, to allow D-SNPs, HIDE-SNPs, and FIDE-SNPs to provide coordinated, whole-person care to enrollees and improve outcomes, costs, and quality. Such integrated care products can also offer opportunities for shared savings and reductions in health disparities.

The MLTSS Association recommends CMS expand access to behavioral health care services in Medicare more broadly. While approximately one in four Medicare beneficiaries has a mental illness, there persist significant barriers to accessing behavioral health care services. MA beneficiaries can lack access to in-network mental health providers, instead turning to higher-cost out of network providers. One 2015 analysis found MA networks to only include 23% of psychiatrists in a county, a smaller share compared to other physician specialties assessed.[8] To help alleviate this issue, CMS should work with Congress to recognize additional types of mental health providers for reimbursement, including licensed professional counselors (LPCs) and marriage and family therapists (MFTs). We appreciate CMS' proposals in the recent Physician Fee Schedule, which allow certain behavioral health workforce types (including LPCs and MFTs) to be able to be reimbursed under general supervision, rather than "direct" supervision.[9]

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[7] The National MLTSS Health Plan Association. Why Include Long-Term Services and Supports in Behavioral and Mental Health Reform. May, 2022. Available at: https://www.mltss.org/post/why-include-long-term-services-and-supports-in-behavioral-and-mental-health-reform

[8] McGinty, Beth. Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement. July, 2020. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities

[9] Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts. 87 Fed Reg. 45860. July, 2022. Available at: https://www.federalregister.gov/documents/2022/07/29/2022-14562/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

CMS should also consider the success that some of our member plans have had better integrating service care delivery with a particular focus on behavioral health. For example, one member plan identified that nearly 70% of their membership had a behavioral health condition. To address this, the plan developed a delegation model that transfers care management responsibilities to community-based providers allowing for intensive and localized care management practices. The model included enhanced payments, daily check ins with the care team, and provider incentives tied to behavioral health-related quality outcomes (e.g., the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure).

Other policy recommendations include an expansion of the settings in which MA plans can provide substance use disorder treatment beyond hospital-based settings and the types of providers that can offer counseling services (e.g., appropriately trained community health workers within the home setting).

B.7. What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS' MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits?

The CHRONIC Care Act significantly expanded the ability of MA plans to tailor supplemental benefits to certain enrollees, through SSBCI. The change allowed MA to cover services that are not primarily health-related, and instead addressed social and economic needs. Currently, SSBCI can be targeted towards chronically ill beneficiaries, defined as someone who 1) has one or more comorbidity medically complex chronic conditions that are life threatening or significantly limit overall health or function, 2) has high risk of hospitalization or other adverse health outcome, and 3) requires intensive care coordination.

There is a need improve care for Medicare beneficiaries with functional impairment. In an analysis of survey and claims data, researchers found Medicare beneficiaries with multiple chronic conditions and functional impairment were more than twice as expensive compared to individuals with multiple chronic conditions but no functional impairment.[10]

The MLTSS Association recommends CMS additionally clarify through guidance that functional need and frailty meet the definition of a chronic condition for determining SSBCI eligibility and waiving uniformity requirements. While current guidance notes that two of the existing eligibility criteria "refer to the function of the enrollee, so [CMS believes] it is sufficiently clear that this is something that can be considered when

[10] Long-Term Quality Alliance. Fulfilling the Promise of the CHRONIC Care Act: Policy Recommendations for Congress to Advance New Supplemental Benefits in Medicare Advantage. May 2022. Available at: https://atiadvisory.com/wp-content/uploads/2022/05/Fulfilling-the-Promise-of-the-CHRONIC-Care-Act-Policy-Recommendations.pdf

determining if an enrollee is a chronically ill enrollee," it remains uncertain whether frailty itself can be used as a factor for eligibility.[11]

Beyond this clarification, the MLTSS Association also recommends CMS and Congress consider an expansion of the types of individuals that can benefit from SSBCI to specifically include individuals with low-income or certain socioeconomic risk factors. Currently this flexibility exists only in CMMI's VBID demonstration program. We support efforts to include that flexibility in the broader MA program.

B.8. How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved?

CMS expanded the definition of primarily health-related benefits in 2019 to allow MA plans to cover supplemental benefits related to services such as adult day care, home-based palliative care, in-home support services, and caregiver support. Despite these new flexibilities under uniformity requirement changes, MA supplemental benefits relatively restricted given the finite number of rebate dollars available to fund such benefits. Most MA plans continue to dedicate much of their rebate dollars toward medical services excluded from Medicare FFS, including vision, dental, and hearing.

Consequently, covering these types of benefits is critical for MA plans to remain market competitive. However, electing to cover expanded benefits can result in a "benefit crowd-out," where MA plans' selection of one novel supplemental benefit effectively precludes them from covering some other benefit that may be equally beneficial. This dynamic stems from the fact that increased supplemental flexibilities have not been paired with corresponding increases in rebate dollars available to pay for such benefits. Despite the risk of crowd-out, D-SNPs cover these types of expanded health-related benefits at higher rates than other MA plans.[12] D-SNPs may also be forced into these situations through requirements in their State Medicaid Agency Contracts (SMAC), which often outline specific supplemental benefits that D-SNPs must offer. CMS should consider other ways of equipping D-SNPs to have the resources to deliver a broader range of supplemental benefits to enrollees. We discuss recommendations for this in our response to questions C.9 and D.1 below.

D-SNPs (and MA plans more broadly) also struggle to provide supplemental benefits that meet the full needs of their beneficiaries. Given the limited availability of rebate dollars, even many of the more common supplemental benefits (e.g., dental, hearing, and vision) are, by necessity, limited. For example, there are certain dental procedures (e.g., extraction, root canals), for which the maximum supplemental benefit only

[11] Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. 85 Fed Reg. 22796. June, 2022. Available at: https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf

[12] Friedman, Julia M. and Yeh, Mary. Prevalence of supplemental benefits in the D-SNP Medicare Advantage marketplace: 2018 to 2022. April 2022. Available at: https://us.milliman.com/en/insight/prevalence-of-supplemental-benefits-in-the-d-snp-medicare-advantage-marketplace-2022

covers part of the cost. As a consequence, beneficiaries may find themselves with unexpected out of pocket costs stemming from services provided through supplemental benefits.

Beyond restrictions associated with the structuring of supplemental benefit packages, D-SNPs must overcome the additional barrier of associated with appropriately translating the value of those benefits to beneficiaries. As discussed throughout this document, D-SNPs are uniquely situated to offer supplemental benefits that complement the Medicaid covered services available to dually eligible beneficiaries. However, for such benefits to meaningfully drive beneficiary behavior in plan selection and retention, as well as motivate beneficiary uptake of the benefits themselves, the context and intent of those offerings must be appropriately expressed. For example, some D-SNPs offer the option to choose from an array of supplemental benefits that best fit their need. However, the intent behind this is to allow for a holistic assessment and coordinated planning of beneficiaries' available Medicaid and Medicare services with the support of a care managers. Thus, while on its face an a la carte style approach to benefits may carry marginal interest for some beneficiaries, its true efficacy is reach when the relationship of that benefit set to beneficiaries' broader covered is explained to beneficiaries.

Finally, D-SNPs that tailor their SSBCI benefits to specific sub populations face the additional task of ensuring that beneficiaries are appropriately aware of whether they fall within relevant target populations and other eligibility criteria. While eligibility criteria are the inherent key feature of SSBCI benefits, translating those criteria into plan-made, CMS-made, and state-made criteria is critical in maximizing the changes of uptake and outcomes of such benefits.

C.7. What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework and Common Agreementto support improved health information exchange for use cases relevant to MA plans and providers?

MLTSS plans enrolling dually eligible beneficiaries may receive Medicare claims data from states through the Coordination of Benefits Agreement (COBA). COBAs permit other insurers and benefit programs to send eligibility information to CMS and receive Medicare claims data for processing supplemental insurance benefits. However, some states limit claims only to services where there is Medicaid cost-sharing. Further, some providers may not choose to bill Medicaid when there is cost sharing as the relatively small reimbursement may not be worth the administrative burden. This is especially common among primary care providers. There are also data lags up of to six months in receiving the claims data, which makes it no longer actionable for MLTSS care managers. Other challenges include missing data elements, mismatched time frames, and time-consuming data cleanup and ingestion. The MLTSS Association recommends CMS facilitate sharing of this data with MLTSS plans. CMS could do so through the creation of state incentives

to share data as well as the development of a centralized Medicare database for all dually eligible beneficiaries that MLTSS plans can access that would include much of this information.

CMS should also encourage standardization of 834 enrollment files, which are used to transfer enrollment information between the state Medicaid agency and MLTSS plans. Each state chooses its own 834 file vendor and file format, leading to significant differences state-by-state. Further, plans often do not receive information in 834 files on whether their dually eligible beneficiaries are in Original Fee-For-Service Medicare or MA, and their Medicare plan information if they are enrolled in MA. CMS should add a standard set of elements to 834 enrollment files across states to facilitate better care coordination for the member, including Medicare program enrollment and plan information for dually eligible beneficiaries. CMS should also consider requiring the inclusion of reason for disenrollment on the 834 files from states. Plans may receive termination transactions with blank reasons and have to perform their own research as a result.

C.8. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

In this year's final Part C and D policy rule, CMS finalized a pathway for states to require standalone D-SNP contracts with corresponding stand-alone Star Rating reporting. The MLTSS Association appreciates that CMS recognizes the unique needs and circumstances of D-SNPs and the population they serve as compared to the broader Medicare population. There is undeniable value in comparing D-SNPs, and we support further exploration and iteration on this.

However, we would like to reiterate some limitations of this policy that relate to how the Quality Performance Program (QPP) relates to D-SNPs. D-SNPs currently have only one set of quality measures unique to them – The Care for Older Adults measure set. Otherwise, D-SNPs are held accountable to the same Star Ratings as non-SNP plans. Despite this near uniformity in quality ratings, there is a strong association between D-SNPs and lower Star Ratings.[13] This trend holds true despite CMS' efforts in mitigating the impact on quality outcomes of dually eligible beneficiaries via the Categorical Adjustment Index. Much of the association between lower outcomes and dually eligible status is attributed to the disproportionately medically complex nature of the dually eligible population.

Plans that operate in states which choose to require standalone D-SNPs will face the prospect of lower Star Ratings outcomes due primarily to the population they serve. Moreover, despite being plans intended to serve a more medically complex – and costly - population, the relative disadvantage in Star Ratings performance will yield a corresponding decrease in available rebate dollars, which directly impacts the

[13] Sorbero, Melony E. et al. Adjusting Medicare Advantage Star Ratings for Socioeconomic Status and Disability. The American Journal of Managed Care VOL. 24, NO. 9. September 2018. Available at: https://www.ajmc.com/view/adjusting-medicare-advantage-star-ratings-for-socioeconomic-status-and-disability

quality and nature of the supplemental benefits these plans will be able to offer. As discussed above, flexibility and creativity in supplemental benefit design is a defining characteristic and value proposition of D-SNPs. Without further consideration of standalone D-SNPs in the broader MA Star Ratings program, CMS risks limiting the ability of such plans to provide the level of integrated care they were originally designed to provide.

We therefore urge CMS to fully consider the consequences of D-SNP only contracts on the broader MA and D-SNP market. CMS could simultaneously assess alternative methods of gathering, disseminating, and comparing D-SNP performance and quality data, perhaps as a separate category of MA quality performance. While current Star Ratings outcomes are reported on at the contract level, and thus combine D-SNP performance with non-D-SNP plans, measure-level performance is collected at the plan level. There may be opportunities for D-SNPs to achieve their goal of D-SNP quality comparison without separating D-SNPs entirely.

C.9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?

With respect to changes to CMMI model demonstrations, the MLTSS Association has two primary sets of recommendations. The first deals with modifications to the existing Value-based Insurance Design model. The second is a set of broader considerations related to more meaningful inclusion of Medicaid managed care organizations in future CMMI model design.

VBID – The Medicare Advantage Value-Based Insurance Design model allows, in part, for extended flexibilities in the use of SSBCI. Many D-SNP plans have taken advantage of these flexibilities to offer tailored benefit designs of both medical and non-medical supplemental benefits for subsets of their populations. The MLTSS Association strongly supports the continued testing and incorporation of these flexibilities into the broader MA program.

However, one persistent reality faced by D-SNPs (and all MA plans) offering any form of SSBCI benefit is the significant limitation that continues to exist on the total number of rebate dollars available to plans to commit to such benefits. Although Congress, CMS, and CMMI have continued to remove barriers for the testing and application of these novel benefits, there has not been any corresponding change to the underlying financing of supplemental benefits. CMMI has available to it the opportunity to test new financing structure for plans offering SSBCI in ways that could incentivize their uptake while maintaining appropriate safeguards against expanded costs of the MA program. For example, CMMI could include a financial incentive in the VBID program for plans that adopt some or any SSBCI benefit to receive a corresponding increase in rebate percentage on their plan bids. This type of incentive would encourage the

uptake and subsequent data collection/testing/proliferation of SSBCI benefits, which in turn will bolster the information needed to make certain elements of the VBID model more permanent in the MA program.

In addition to changes related to the funding of SSBCI benefits, we also recommend that CMMI use its authority to test the inclusion of functional status within the existing CMS-HCC risk adjustment model. The current model's focus on disease-state acuity calculations precludes the type of whole person functional perspective taken by LTSS care management approaches. We explore this recommendation in more detail in our response to question D.2 below.

Inclusion of Medicaid MCOs in Future CMMI Models - The MLTSS Association was fortunate enough to assist CMMI in the development of the former MCO-based Direct Contracting Entity (DCE) for the Global and Professional Direct Contracting model (now ACO Reach).[14] The fundamental goal we mutually – the MLTSS Association and CMMI - sought to achieve was to ensure that MLTSS plans, which are responsible for the care of LTSS services for millions of Medicare fee-for-service beneficiaries, would be able to provide whole-person care in collaboration with beneficiaries' fee-for-service Medicare service providers in future CMMI models. Currently, whether in the context of CMMI models or elsewhere, there is limited structural collaboration or integration between MLTSS plans and Medicare providers.

Although CMMI subsequently chose to eliminate the MCO-based DCE as a component in the ACO REACH model, CMMI continues to recognize the need to meaningfully transition individuals into "accountable care relationships."[15] More specifically, CMMI has committed itself to move all Medicare beneficiaries, including dually eligible beneficiaries, into such relationships in way that will "manage the quality and cost of their care and improve their care across the Medicare and Medicaid programs."[16] CMMI also committed to ensuring "that Medicaid beneficiaries – in managed care and FFS programs – are not only attributed to a provider but also in arrangements that drive accountability for quality, outcomes, and costs."

We believe that there is no practical way for CMMI to achieve these lauded goals without the intentional incorporation and collaboration with Medicaid MLTSS plans. Furthermore, we believe that some of the practical operational and administrative elements of incorporating MLTSS plans into the Medicare environment have already been solutioned for in the MCO-based DCE track. For example, through concerted collaborative effort with our plan membership, CMMI was able to develop a unique beneficiary alignment process that did not rely on the default claims-based alignment process used in other tracks of the model. Moreover, the conversations around the development of the model led to meaningful evolutions in CMMI's understanding of Medicaid and Medicaid managed care – particularly in data collection differences in the Medicare and Medicaid programs.

[14] The MCO-based Direct Contracting Entity option was announced in December, 2020. In March of 2021, CMMI implemented paused the implementation of the Geographic direct contracting entities as well as the MCO-based Direct Contracting Entity option. In the beginning of 2022,

[15] The term "accountable care relationship" is introduced as part of CMMI's October, 2021 Strategy Refresh.

[16] Id.

While we recognize that the Direct Contracting and ACO REACH models have evolved since the introduction of the MCO-based DCE option, we nevertheless strongly recommend CMMI to use the substance and solutions incorporated in that track as the starting point for iterative changes in other existing or future models. More broadly, we highly recommend that CMMI re-engage with Medicaid managed care plans; particularly MLTSS plans who are responsible for the primary set of Medicaid benefits that dually eligible beneficiaries receive. From our perspective, without such engagement and collaborative solutioning, CMMI will not be able to achieve its stated goals for Medicaid and dually eligible beneficiaries.

D.1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

The MLTSS Association recommends several modifications to existing MA payment policies. These include:

Uniform Application of the D-SNP Frailty Adjuster – Currently, FIDE SNPs are the only D-SNP plan type that are eligible to receive the frailty adjustment to their capitation rates. This adjustment is available to FIDE SNPs only if the plan has an average frailty score equal to or above the annually updated Program of All-Inclusive Care for the Elderly (PACE) frailty score (as measured by plan participation in the Health Outcomes Survey or Health Outcomes Survey-Modified). The frailty adjuster is authorized under SSA Section 1853(a)(1)(B)(iv).

The MLTSS Association has consistently recommended the expanded application of the frailty adjuster to all highly integrated products. The distinction between FIDE SNPs and other SNP plan types (HIDE and Coordination-only) almost uniformly stems for individual state policy decisions in the management of their Medicaid services, and not demographic or acuity makeup. If states choose not to "carve in" MLTSS and behavioral health services into their Medicaid programs, then no plans operating in that state will achieve FIDE SNP status. Despite this, the beneficiary demographic and acuity scores between across D-SNPs are very similar. Thus, the problem that the frailty adjuster was intended to solve for – disproportionate financial impact of high acuity frail individuals – is faced by all types of D-SNPs. Yet many of those SNPs cannot avail themselves of the existing policy solution for that problem for reasons entirely outside of their control. Moreover, because states are primarily responsible for determining the level of integration options available to MA plans, the frailty adjuster cannot meaningfully act as an incentive for MA plans to stand up FIDE SNPs over other less integrated options.

While the MLTSS Association recognizes that the parameters of the frailty adjuster are outlined in statute, we nevertheless encourage CMS to consider any and all options within their regulatory authority to either extend its application, or to create alternative solutions available to other SNP plan types.

Recent Changes to MOOP calculation for dually eligible beneficiaries – In the recently finalized Part C and D final rule, CMS finalized a new policy that adjusts what payments are considered when calculating a

Medicare beneficiary's maximum out of pocket (MOOP) costs.[17] Specifically, CMS now requires that all costs for Medicare Parts A and B services accrued under the plan benefit package – including cost-sharing paid by any applicable secondary or supplemental insurance and cost-sharing that remains unpaid because of limits on Medicaid liability for Medicare cost-sharing under lesser-of policy and the cost-sharing protections afforded certain dually eligible individuals – is counted towards the MOOP limit. CMS implemented this policy to create greater parity between D-SNP and non-D-SNP MA plans, to ensure providers receive an equivalent amount of cost-sharing payments for dually eligible beneficiaries, and to decrease cost sharing obligations paid by state Medicaid agencies on behalf of dually eligible beneficiaries.

The MLTSS Association appreciates the policy objectives sought to be achieved by this policy change, but we continue to question whether it will achieve its stated outcome. Specifically, membership plans have stated that, based on their modeling, this change is not expected to change the speed at which most of their D-SNP enrollees reach their MOOP. Moreover, in circumstances where MOOP is achieved faster, the additional payments covered by MA plans are likely to increase bid costs. CMS recognized this effect in its own modeling in the final rule estimating that the changes would increase federal outlays by $3.9 billion over 10 years (but decrease federal match spend for Medicaid by about $2.7 billion).[18]

SSBCI Supplemental Benefit Rebate Reform – As outlined in responses to questions B.7, B.8, and C.9 above, D-SNPs rely on the opportunities to provide targeted supplemental benefits that meet the specific needs of their beneficiaries. However, despite the introduction of these increased flexibilities, little has changed in the underlying payment structure of supplemental benefits. As we outlined in our recommendations in question C.9 related to the VBID model, this lack of payment reform for supplemental benefits limits their potential efficacy and plan creativity. We therefore encourage CMS to consider payment reforms that are intended to specifically incentivize the uptake of novel supplemental benefits.

One possibility we have already proposed in question C.9 would be to increase the rebate percentage for plans offering SSBCI benefits as an incentive to plans. The change could be paired with appropriate guardrails, such as a requirement that any additional bonus rebate dollars must be spent on SSBCI benefits. Further, CMS could consider limiting the availability of this incentive to targeted geographies with the highest identified need (perhaps relying on data from such sources as the Area Deprivation Index).

D.2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

[17] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. 87 Fed. Reg. 27704, 27706. May, 2022. Available at: https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf

[18] Id.

As we stated in question C.9, the MLTSS Association recommends that CMS more effectively incorporate functional status with the existing MA risk adjustment model. As stated in a 2018 Government Accountability Office report, the MA risk adjustment model underestimates spending on individuals' functional status and their ability to perform daily activities such as bathing or dressing.[19] The report goes on to highlight the challenges associated with collecting the data needed to inform the inclusion of such functional information in the risk adjustment process, stating in relevant part that "nearly three-fourths of beneficiaries do not receive health care in settings where functional status information is routinely collected."[20] Currently, the only functionally-informed payment adjustment in the MA payment system is the FIDE SNP frailty adjuster, which is limited to a very small subset of plans and tied to the use of the HOS and HOS-M surveys.

The MLTSS Association recognizes the challenges associated with collecting and operationalizing functional status data. There is no uniform standardized approach in collecting functional status because of a plethora of assessment tools. Moreover, the translation of that data into usable encounter or claims level information poses a challenge. Nevertheless, it is important to note that despite these restrictions, such information serves as the basis for a vast portion of eligibility and service delivery determinations in the LTSS environment. More importantly, despite these challenges, state Medicaid agencies are already performing rate setting actions for MLTSS plans using functional status. For example, New York and Wisconsin are both using rate setting process that relies on encounter-level data reported by their Medicaid managed care organizations.[21] This experience can serve as an important reference point for changes to the existing MA risk adjustment model.

While we recognize the multitude of steps it would take in order for CMS to meaningfully incorporate functional status into the MA risk adjustment process, the MLTSS Association strongly believes that CMS does not have to start from scratch. Learning from best LTSS rate setting practices and collaborating with state Medicaid and MLTSS plans on data collection activities would serve as a strong starting point. We welcome the opportunity to discuss these issues with you further.

Conclusion

Thank you for the opportunity to provide input on the future of the critically important MA and D-SNP programs. The MLTSS Association looks forward to opportunities to engage directly with CMS as it moves towards a more integrated delivery model of the Medicare and Medicaid programs.

If you have any questions, please contact me at mkaschak@mltss.org.

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[19] Government Accountability Office. Benefits and Challenges of Payment Adjustments on Beneficiaries' Ability to Perform Daily Tasks. September, 2018, GAO Publication No. 18-588. Available at: https://www.gao.gov/assets/gao-18-588.pdf

[20] Id.

[21] Center for Health Care Strategies, Inc. Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations. January, 2016. Available at: https://www.chcs.org/media/MLTSS-Rate-Setting_Final1.pdf.

Sincerely,

Mary Kaschak
Chief Executive Officer