January 17, 2025

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

Re: Proposed Rule on Policy and Technical Changes to Medicare Advantage for Contract Year 2026 (CMS-4208-P)

Dear Administrator Brooks-LaSure,

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule: Medicare and Medicaid Programs; 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, 89 Fed. Reg. 237 (December 10, 2024).

It has long been the Commission's view that integrated care has the potential to improve care for dually eligible beneficiaries, eliminate incentives for cost shifting between Medicare and Medicaid, and reduce spending that may arise from duplication of services or poor care coordination (MACPAC 2020). Dually eligible beneficiaries may experience fragmented care and poor health outcomes when their benefits are not coordinated (CMS 2024a). In 2024, more than 6 million dually eligible beneficiaries received their Medicare, and sometimes their Medicaid, benefits through Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), making that model the primary vehicle for integration (CMS 2024b). In our June 2021 report to Congress, MACPAC described the contracting strategies available to states through their state Medicaid agency contracts (SMACs) to increase integration in D-SNPs (MACPAC 2021). Then, we examined how states choose to implement, oversee, and enforce SMAC provisions to integrate care for dually eligible individuals, including the challenges that states face in doing so. Our findings led the Commission to recommend that states require D-SNPs to submit data on care coordination and MA encounters (MACPAC 2024).

Additionally, the Commission has historically voiced concerns about shifting costs from Medicare to Medicaid for dually eligible individuals. When different entities bear risk for Medicaid and Medicare services, there is an opportunity to shift costs from one program to the other. For example, a state Medicaid agency may be disinclined to pay for additional services in a nursing facility that could prevent hospital readmissions because the financial risks of subsequent hospitalizations would be borne by Medicare. On the other hand, Medicare may seek to limit its spending by discharging patients from the hospital more quickly, which could lead

to beneficiaries requiring a greater level of long-term services and supports (LTSS), a benefit covered by Medicaid (MACPAC 2023).

The proposed rule would make mandatory coverage of certain weight loss drugs for obesity through Medicaid, for which states will need to develop coverage criteria, and may create the risk that costs could temporarily shift from Medicare to Medicaid for dually eligible individuals. The proposed rule would also make a number of changes affecting dually eligible beneficiaries. It would establish new integration requirements for applicable integrated plans (AIPs), which are D-SNPs that operate with exclusively aligned enrollment (EAE) where only full-benefit dually eligible beneficiaries that receive their Medicaid and Medicare benefits through the same parent company are enrolled. It would also codify CMS timelines for MA special needs plans (SNPs) to conduct health risk assessments (HRAs) and develop individualized care plans (ICPs), as well as make changes intended to improve awareness and transparency of cost-sharing tools. Our comments in this letter draw on the Commission's prior work and highlight relevant MACPAC recommendations that CMS may choose to consider as it moves to finalize the proposed rule.

Mandatory Medicaid coverage of anti-obesity medications

Under the Medicaid Drug Rebate Program (MDRP), drugs used for anorexia, weight loss, or weight gain can be excluded from coverage or otherwise restricted (§ 1927(d)(2)(A) of the Social Security Act (the Act)). To date, this statutory provision has included anti-obesity medications (AOMs) such as the class of drugs called glucagon-like peptide-1 (GLP-1s) that can be prescribed to reduce weight and maintain weight loss. The definition of a Part D covered drug (§1860D-2(e) of the Act) is tied to the definition of covered outpatient drugs under the MDRP (§1927(k)(2) of the Act), and as such, coverage of AOMs has been excluded from Part D coverage. In the proposed rule, CMS proposes to interpret the statutory language in Section 1927(d)(2)(A) of the Act to allow for certain drugs that are used to treat obesity by managing weight to match the contemporary medical understanding of obesity as a chronic disease (CMS 2024c). Under this interpretation, coverage of AOMs when prescribed for the treatment of obesity would be mandatory under Medicare Part D and Medicaid; coverage of AOMs when prescribed for overweight would still be excluded from coverage under Medicare Part D and optional under Medicaid.

The Commission recognizes the health benefits and potential long-term savings that coverage of AOMs could provide; however, we are concerned that CMS creates the risk for temporarily shifting the cost of these AOMs from Medicare to Medicaid for dually eligible beneficiaries should the agency issue different applicability dates for the coverage mandate in each program. Additionally, the agency should issue clear guidance to states on appropriate prior authorization (PA) criteria in the absence of a definition of obesity.

Effective date. The proposed rule introduces the possibility of a gap in the effective date for mandatory coverage in Medicare and Medicaid, which could create the potential for cost shifting to the Medicaid program for dually eligible individuals. Statute prevents CMS from implementing new, significant regulatory requirements on a Part D plan except at the beginning of a calendar year. If the proposed rule is finalized in 2025, mandatory Medicare coverage of these drugs would not begin until January 1, 2026 (§ 1860D-12(f) of the Act and 42 CFR 423.516). However, in Medicaid, the coverage requirement could begin upon the effective date of the rule, which would generally be 60 days after the rule is finalized. Typically, Medicaid does not cover the cost of Part D drugs nor cost sharing for dually eligible beneficiaries (§ 1935(d)(1) of the Act). However, a difference in effective dates for Part D and Medicaid coverage could mean that Medicaid would be required to cover AOMs for dually eligible beneficiaries until coverage began under Part D.

The statutory exclusion of Medicaid coverage of Part D drugs or cost sharing for full-benefit dually eligible beneficiaries is tied to the definition of a Part D eligible individual (as defined in § 1860D-1(a)(3)(A) of the Act) rather than the definition of a covered Part D drug (§ 1935(d)(1) of the Act). Consequently, it is possible to

interpret that states would not need to cover AOMs during the interim period before Part D coverage of AOMs began because full-benefit dually eligible beneficiaries would be Part D eligible individuals. Statute allows for coverage of Medicaid covered outpatient drugs that are not otherwise a covered Part D drug furnished to an individual who is enrolled in a Part D plan, but this would be at the state's option and coverage would be in the manner otherwise provided in the case of individuals who are not full-benefit dually eligible beneficiaries (§ 1935(d)(2) of the Act).

In the Commission's view, CMS should consider linking the effective date of mandatory Medicaid coverage of AOMs to the effective date for Medicare Part D as it avoids the possibility of cost shifting between programs and removes the potential for confusion over coverage for dually eligible beneficiaries. If CMS does not believe it can delay the effective date for Medicaid coverage, the agency should issue guidance to clarify for states their role in providing coverage for full-benefit dually eligible individuals prior to Part D coverage of AOMs for obesity.

Guidance on coverage and PA criteria. It is the Commission's view that CMS should issue guidance to states detailing reasonable criteria (e.g., definitions of obesity) for purposes of developing PA and coverage policies. States have several tools they may use to control the costs of covering prescription drugs, including PA and establishing preferred drug lists. In proposing mandatory coverage of AOMs, CMS notes that states will continue to have access to these tools. However, since the proposed rule does not include a definition of obesity, there could be a range of metrics used to define obesity across Medicare and state Medicaid programs.

CMS proposes that Part D plans will have flexibility to determine PA criteria for AOMs as long as the criteria are not more restrictive than the U.S. Food and Drug Administration (FDA) labeling for the particular drug. The proposed rule also notes that indications for some AOMs approved by the FDA have been revised to remove references to specific body-mass indices (BMIs), which several states currently use as a coverage criterion in covering AOMs for obesity or overweight (Williams et al. 2024). This raises the question of whether states could implement PA criteria referencing common definitions of obesity (e.g., a BMI of 30 kg/m^2 or greater) even if not included on the FDA label. Therefore, it is critical that CMS provide guidance on how states can avoid paying for AOMs for overweight individuals who are excluded from coverage under Medicare Part D, and optional for coverage under Medicaid, while covering AOMs for individuals meeting the new CMS interpretation of chronic obesity. In prior work, states told MACPAC about the challenges of developing coverage policies (MACPAC 2019). In addition, pharmacy and medical directors shared that determining coverage and PA criteria that align with the drug's labeling and medically accepted indications can take one to three months or longer. Guidance from CMS would provide states with greater certainty in developing their PA criteria, especially as CMS only proposes to mandate coverage of AOMs for obesity and not for those with overweight, which may be a difficult distinction to make without a formal definition of obesity.

Integrated care requirements for dually eligible beneficiaries

The Commission supports efforts to increase the availability and accessibility of, and the level of integration offered in, integrated care models for dually eligible individuals. Many of the proposed provisions on integrated care for dually eligible individuals seek to codify existing CMS guidelines, while others seek to formally require integration efforts for AIPs that are already commonplace. As prior CMS rulemaking will likely increase the number of AIPs by 2030, the Commission approves of CMS efforts to ensure that these plans make use of simple integration tools that could improve beneficiary experience (CMS 2024d).

We also support establishing specified timelines for conducting HRAs and developing ICPs in regulation as the timely completion of these activities are central to providing care coordination. The Commission also supports including language that directs D-SNPs to defer to state requirements for these activities as described in the SMAC.

Integration requirements for AIPs. The proposed rule would add requirements that AIPs must provide enrollees with one integrated member identification (ID) card, which would need to comply with existing regulations for both MA plan IDs and Medicaid managed care plan IDs. Most states with AIPs already require a single ID card in their SMAC with a few exceptions. MACPAC's prior work on contracting strategies for D-SNPs found that EAE D-SNPs have the opportunity to increase integration by offering a single set of member materials, such as an integrated member ID card (MACPAC 2021). Evaluations of Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative (FAI) demonstration, which first required an integrated member ID and from which a number of integration tools have been incorporated into D-SNP requirements, regularly found that beneficiaries appreciated having one insurance card (MACPAC 2022). States that participated in the FAI, which are now transitioning their MMPs to AIP D-SNPs, will also require their plans to provide an integrated member ID card (CMS 2024c). In April 2024, CMS finalized new MA regulations that would require certain D-SNPs with affiliated Medicaid managed care plans to operate with EAE by 2030; those regulations will create AIPs that would need to follow this proposed change in ID card requirements (CMS 2024d). As the number of AIPs increase, including across states that may have less experience with optimizing their SMAC, the Commission supports efforts by CMS to ensure standard integration elements that improve the beneficiary experience and make integrated coverage more person-centered by responding to beneficiary preferences, such as requiring integrated ID cards.

The Commission also supports CMS's proposal to require AIPs to use a combined HRA process, which will reduce the burden on beneficiaries faced with multiple rigorous, intensive assessments for Medicare and Medicaid. The change also has the potential to streamline the beneficiary experience for individuals who are dually eligible relative to individuals who are not enrolled in both programs and therefore not subject to multiple assessments. CMS clarified in a prior rule that D-SNPs may combine their HRA instrument with required Medicaid assessments, as well as align it with other assessment tools (CMS 2021). Several states already use a combined HRA, such as Arizona, and states also did so for the MMPs through the FAI (CMS 2024c).

Timelines for HRAs and ICPs. For individuals enrolled in a SNP, health plans must develop a person-centered ICP informed by the results of the HRA and by the enrollee's goals (42 CFR 422.101(f)(1)(ii)). Upon identifying deficiencies among some health plans in completing ICPs in a timely manner and with appropriate specificity, CMS proposes to codify a timeline for conducting HRAs and completing ICPs. The proposed rule would require SNPs to conduct HRAs within 90 days before or after an individual's effective date of enrollment, as well as to develop and implement a comprehensive ICP that is person-centered and developed with active participation of the enrollee or their representative within 30 days of conducting the initial HRA or 30 days after the effective date of enrollment, whichever is later (CMS 2024c). The Commission supports codifying existing timelines for HRAs and ICPs, including expectations around person-centeredness. We offer one caution that these minimum timelines can pose a risk for individuals in urgent need of Medicaid LTSS – including home- and community-based services, behavioral health services, or other supports to delay or prevent institutionalization – who may need to seek institutional care if their home- and community-based needs are not addressed promptly.

Several states recognize the need for more timely completion of the HRA and require a shorter timeline through the SMAC, such as Minnesota (MACPAC 2024a). As CMS finalizes these provisions, the Commission supports the inclusion of language instructing D-SNPs to defer to and comply with state timeline requirements, where applicable, when they are shorter than federal minimums, particularly with regard to services and supports that might delay institutionalization. Our recent work on optimizing SMACs found states with mature integrated D-SNPs typically set requirements in their SMACs around HRA completion and including specific Medicaid services in the ICP (MACPAC 2024a). This finding shows the importance states place on these tools for delivering integrated care in a timely way to meet the needs of beneficiaries, including those who are at risk of institutionalization.

CMS also proposes to require SNPs to document their attempts to contact enrollees who cannot be reached to conduct HRAs and develop ICPs, or who decline to participate (CMS 2024c). The Commission supports this effort to increase transparency, which will assist both CMS and states in conducting oversight of D-SNPs.

Publishing SMACs. CMS also asks for comment on whether the agency should publicly post SMACs. In the Commission's June 2024 report to Congress, we conducted a review of contract year 2023 SMACs in order to identify commonly used provisions. MACPAC did not identify any confidential information in these documents during our own review that would prohibit them from being released publicly. Notably, several states regularly post their model contracts. However, the scope of our review did not include the identification of proprietary information and it is possible that states or health plans may have specific concerns. In our research, federal and state officials highlighted the challenges that state Medicaid agencies face in developing and retaining D-SNP expertise, and they shared that some states are still learning how to effectively use a SMAC to leverage integration in D-SNPs (MACPAC 2024a). While technical guidance, including model contract language, is available to states through organizations like the Integrated Care Resource Center, states have also expressed interest in learning from their peers. The Commission supports transparency in sharing SMACs publicly.

Access to cost-sharing tools

The Commission supports efforts to increase awareness of Medicare cost-sharing supports for those who may be dually eligible, including increasing enrollment in Medicare Savings Programs (MSPs). In its proposed rule, CMS would require Medicare brokers and agents to provide information to beneficiaries on their potential eligibility for cost-sharing supports, such as the MSPs, and to connect interested individuals with the state for further information. Additionally, CMS includes several requirements regarding the administration of MA supplemental benefits via debit card, including cost-sharing reductions. While the Commission does not directly comment on Medicare requirements that are unlikely to affect dually eligible beneficiaries who have their cost-sharing covered by Medicaid, we recognize the proposed guardrails for advertising debit cards in MA plans as these attractive cash or "flex" cards can draw dually eligible beneficiaries who would be better served in an integrated care model.

Improving awareness of MSPs. The Commission has previously voiced concern about low levels of enrollment into the MSPs by those eligible for the programs. In our June 2020 report to Congress, the Commission recommended two changes to federal law that would streamline eligibility determinations and improve information sharing between the Social Security Administration and the states (MACPAC 2020). Recently, we identified improvements in MSP enrollment from 2010-2021 that showed a substantial majority of eligible individuals were enrolled in MSPs (MACPAC 2024b). However, millions eligible for the MSPs, which would reduce their out-of-pocket costs for Medicare, remain unenrolled.

After an ongoing review of broker and agent sales calls for MA and Part D plans, CMS noted gaps in information provided to beneficiaries on their potential eligibility for cost-sharing supports, such as the MSPs (CMS 2024c). Existing regulations include a required list of topics for brokers and agents to discuss with beneficiaries (42 CFR 422.2274(c)(12)(v) and 42 CFR 423.2274(c)(12)(iv)). In the interest of better informing beneficiaries of their choices when electing coverage, CMS proposes adding MSPs, along with the Part D Low-Income Subsidy and supplemental Medigap insurance, to that list. To support beneficiaries in this process, which can be complex, CMS also proposes requiring brokers and agents to pause to ask if a beneficiary has outstanding questions prior to electing enrollment. Brokers and agents would also be required to review resources on state programs, like the MSPs, with beneficiaries and offer to connect them with a contact at the state program (CMS 2024c). The Commission is supportive of requirements to improve awareness of these programs and to better connect beneficiaries with state contacts who could enroll them.

Administration of MA supplemental benefits via debit card. While MACPAC has not conducted specific work on the use of debit cards in MA, their use as a marketing tactic is noticeable in its effect on enrollment in

integrated programs, such as the MMPs. Several evaluations of the MMPs included findings from state officials and health plan representatives that enrollment suffered in part due to competition from MA plans (MACPAC 2022).

As CMS identified a growing number of advertisements that highlighted debit cards and their dollar value, CMS proposes prohibiting MA organizations from marketing the dollar value of a supplemental benefit or how it is administered, as well as requiring plans to specify in their materials the supplemental benefits offered and which are accessible via debit card. Tighter controls and more transparency on MA plans may provide dually eligible beneficiaries with greater informed choice.

Thank you for the opportunity to comment on this proposed rule. We appreciate CMS's continued efforts to promote integration of Medicaid and Medicare for dually eligible beneficiaries. Please let us know if there is additional information MACPAC can provide to assist in your consideration of our comments or that would be helpful as you finalize the proposed rule.

Sincerely,

Verlon Johnson, MPA
Chair

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