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March 7, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Comments on the Proposed Rule issued January 6, 2022, file code CMS-4192-P: “Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs”

Dear Administrator Brooks-LaSure:

On behalf of the Massachusetts Medicaid program (MassHealth), I am writing to provide comments on the Centers for Medicare and Medicaid Services’ (CMS) January 6, 2022 proposed rule: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. MassHealth appreciates the intent of the proposed rule and is grateful for the opportunity to provide comments on the issues raised by the rule.

MassHealth is the Massachusetts Medicaid and Children’s Health Insurance Program (CHIP). MassHealth provides coverage to over 337,000 individuals who also have Medicare (dual eligible members). While most (61%) of our dual eligible members receive both their Medicare (Parts A and B) and their Medicaid services via fee-for-service (FFS), a growing number are served through capitated integrated or coordinated care delivery systems, including more than 32,000 adults with disabilities in Medicare-Medicaid Plans (MMPs) under a capitated Financial Alignment Demonstration (One Care), approximately 62,000 older adults in a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) model for members ages 65 and older (Senior Care Options-SCO), and approximately 4,500 older adults in Programs of All Inclusive Care for the Elderly (PACE).

Introduction

Massachusetts is a national leader in integrated care delivery, and has implemented advanced, innovative, person-centered care strategies focused on the needs of younger dual eligible adults with disabilities through our One Care program. Medicare and Medicaid represent some of the most complex state and federal programs that serve some of the most vulnerable individuals. Dual eligible individuals and, in particular, younger dual eligible adults, have complex medical, behavioral health, and social needs and often face health inequities caused by institutional racism and other systemic disadvantages. To reduce barriers to care for these individuals, it is imperative that health plans, states, and the federal government have the authorities and systems in place to work together to make the member experience truly seamless, navigable, equitable, and member centered. MMPs, like One Care, offer the tools necessary to ensure these goals can be met by fully integrating elements like member experience, enrollment, quality measurement, financing, administration, and oversight for integrated health plans.

The changes CMS proposes in the rule represent progress to enhance integration for many D-SNPs, and we support these additional steps towards integration. Indeed, Massachusetts has already implemented many of these same steps in our SCO FIDE SNP program, which serves dual eligible and Medicaid-only members ages 65 and older. Additional proposed flexibilities (HPMS access, D-SNP only contract numbers, exclusively aligned enrollment) generally align with design elements we have already implemented or proposed to CMS in our Duals Demonstration 2.0 proposal^[1] for SCO.

Furthermore, Massachusetts appreciates CMS' recognition of the necessity of state-federal partnerships, the need for technical assistance for states to attain integration goals, and the importance of robust monitoring and oversight for success and for improving member experience. In addition, Massachusetts appreciates CMS's goal of establishing more permanent mechanisms to sustain integrated programs beyond demonstrations.

In considering the proposed transition for MMPs to D-SNPs, however, the enhanced flexibilities and incremental improvements proposed by CMS for D-SNPs may actually represent a step backwards for states, like Massachusetts, with more advanced integrated care delivery systems. Massachusetts is significantly concerned that the proposed sunseting of MMPs would leave substantial gaps in the ability to continue to support the integrated member experience that has been established and nurtured for over eight years through One Care under the current Duals Demonstration, and what was sought in the expansion of the SCO population by bringing SCO under the umbrella of the proposed Duals Demonstration 2.0. By requiring a separation between the Medicare and Medicaid benefits, the proposed transition from MMPs to D-SNPs could erode the level of integration and the person-centered model of care currently available to MMPs, like One Care.

Massachusetts is also concerned that the proposed rule does not fully address how states can achieve or maintain true integration of care under the proposed transition of MMPs to D-SNPs. Fully integrating Medicare and Medicaid benefits and delivery systems for dual eligible members requires a careful analysis of the interplay of enrollment, member experience, quality measurement, financing, administration, and oversight. The impact of the proposed rule, and in particular on the proposal to transition MMPs to D-SNPs, on each of these key areas of integration is discussed more fully below.

We strongly urge CMS to collaborate with Massachusetts and other states to identify additional solutions and flexibilities to address these key areas of integration for programs serving dual eligible individuals **prior** to any transition from MMP to D-SNP.

^[1] Duals Demonstration 2.0 Final Concept Paper submitted to CMS August 22, 2018: [Concept Paper | Mass.gov](#)

Enrollment and Member Experience

As a first order member protection, Massachusetts recommends that CMS provide flexibility for enrollment and disenrollment functions to be operationalized through state Medicaid agencies, including handling of aligned Medicare enrollment transactions. States (including through contracted Medicaid enrollment brokers) are well positioned to handle enrollment transactions impartially and help members to objectively identify plan options and fit, including by providing members independent health plan choice counseling. Consolidating health plan enrollment for dual eligible members ensures that all members have a uniform experience and receive consistent messaging and reduces the possibility that members encounter improper enrollment tactics. Today, MassHealth retains responsibility for enrollment functions for our MMPs and other Medicaid managed care members and finds the approach preferable to the efforts needed to monitor and oversee multiple plans conducting these functions under a D-SNP model. Consolidating enrollment functions is critical to ensuring members have access to fair, equitable treatment and clear, transparent communication and therefore should be addressed in the final rule.

Integrated Member Materials

We appreciate CMS' proposal to create core integrated materials (Evidence of Coverage, Annual Notice of Change, Summary of Benefits, Formulary, and Provider and Pharmacy Directory), and we note that we already have these in use in SCO. **MassHealth strongly believes that members should receive unified communications and materials that speak cohesively about the full scope of each program from the member perspective, paying particular attention to linguistic and cultural competence and accessibility for people with disabilities.** The approach to integrated materials used in MMPs today comes closer to achieving this vision relative to MassHealth's experience with integrated member materials in SCO. In addition, we recommend that the member protections Massachusetts has implemented through its One Care contract, including access to clear, understandable, and culturally appropriate materials in accessible formats and languages other than English, be preserved and applied to both the Medicaid managed care and D-SNP parts of FIDE SNPs.

We further caution that CMS' rulemaking does not go far enough to effectuate integration relative to the level achieved through MMPs, and additional solutions are needed to address this. Specifically:

- CMS should collaborate with states to develop a regulatory or other framework that aligns Medicaid managed care and D-SNP requirements into one clear set of governing rules for integrated materials.
- States need clear discretion and authority to direct the inclusion of state-specific policy and requirements in the integrated materials. This has historically been a time and resource intensive barrier in our SCO program. Without such state-specific policy and requirements, integrated materials may not accurately reflect programmatic realities including important member-facing information such as cost-sharing responsibilities and eligibility rules.

Exclusively Aligned Enrollment for FIDE SNPs

We applaud CMS' efforts to refine the definition of FIDE SNPs to require exclusively aligned enrollment. However, we note that the Massachusetts design of both the current FIDE SNP and MMP products goes beyond this approach in requiring that a dual eligible member who is enrolled in a FIDE SNP or MMP *must* enroll in that plan for both their Medicare and Medicaid benefits. This substantially improves integration for all MMP and FIDE SNP enrollees.

As proposed, the transition from MMP to D-SNP authority limits a state's options to encourage enrollment in integrated products when paired with the removal of authority to passively enroll individuals in these products for their Medicare coverage. Consequently, the more integrated approaches

used in Massachusetts would be subject to additional limitations without an ongoing mechanism for passive enrollment. CMS should consider allowing states to treat acceptance of passive enrollment into the Medicaid MCE portion of the product as acceptance and self-selection into the Medicare (FIDE SNP) portion of the integrated product.

Passive Enrollment

The ability to passively enroll individuals into MMPs instead of FFS has served as an important tool for Massachusetts to grow enrollment in One Care, and it is a tool that we have sought to add for SCO through our proposed Duals Demonstration 2.0. For One Care in particular, Massachusetts has used this tool to support attainment of plan enrollment levels necessary to sustain the program and ensure plan viability under the model. While seamless enrollment may be an option for states to encourage newly eligible individuals to enroll into integrated products, it is structurally constrained to favor organizations with Medicaid managed care products available in multiple state delivery systems. Passive enrollment, coupled with seamless enrollment options, would balance plan enrollment opportunities and support the viability of specialty plans that may not operate non-dual eligible plans within the state.

Further, we encourage CMS to consider circumstances in which passive enrollment into integrated plans, including FIDE SNPs, would be preferable to enrollment into fragmented Original Medicare (FFS) for Medicare A/B benefits, standalone Part D plans, and FFS Medicaid coverage. For example, CMS should allow states to conduct targeted passive enrollments into high performing FIDE SNPs when individuals are already required to change their health coverage, such as when gaining access to either Medicare or Medicaid, and when a member's current Medicare Advantage or Part D plan is ending.

Additionally, in the absence of passive enrollment, plans' exclusive reliance on marketing to attract enrollments diverts health plan spending to marketing and may incentivize certain undesirable marketing tactics. In addition, plan-driven marketing and enrollment infrastructure would likely increase administrative costs of plans. People with disabilities require a more person-centered and independent approach to determining whether a particular plan will meet their needs than is possible through broad-based marketing approaches.

Moreover, health plans developed to meet the needs of disabled populations require considerable infrastructure that benefits from the ability to plan needed levels of staffing and accommodations in a predictable manner. Predictable future enrollment volume helps plans ensure they are staffed appropriately to onboard and assess new members. Without this stability, under- or over-staffing/resourcing may undermine enrollee experience and financial sustainability of the plan.

In its preamble to the proposed rule, CMS acknowledged the need to tie enrollments to plan quality. CMS should consider a similar approach to passive enrollment and should work with states and stakeholders to determine the quality and/or member experience markers to indicate that plans are appropriate to accept additional members through passive enrollment. We recognize that members should have the option to choose whether they want to receive services through integrated arrangements rather than via the FFS option. We also recognize that the advantages of integrated care may not be immediately apparent to members when they have a wide variety of competing options to choose from. Take-up rates of disabled populations in traditional Medicare Advantage plans in Massachusetts have been notoriously low, and we should expect a similar reaction to plans offered through the proposed rule. Given the importance of integrated care for dual eligible persons with disabilities in Massachusetts, however, there should be significant tools to engage and inform members, including opt-out passive enrollment tied to robust member protections, possibly including continuity of care periods for new enrollees and the ability to easily opt out to another plan or FFS.

MassHealth is interested in engaging stakeholders, health plans, and CMS in developing the right set of considerations and metrics to indicate that passive enrollment in any given plan would or could benefit members. For example, CMS required our Demonstration to adopt an “intelligent assignment” approach to passive enrollments. This required MassHealth to review the existing significant providers for a given member in relation to the health plan’s provider network for passive assignment. CMS should consider a similar approach in its final rule, with an additional layer on top of that to require that quality and member experience be considered in determining passive enrollment decisions or approvals. Passive enrollment provides an additional lever for states in creating an environment of “race to the top” and Massachusetts urges CMS to consider ways to maintain this option for states.

Frequency of Enrollment Changes

Massachusetts has preserved the ability for dual eligible members to enroll in One Care, change One Care plans, and disenroll from One Care on a monthly basis. This is an important member protection and alignment tool to which states need access based on the design and alignment of their integrated care programs. CMS should allow states the flexibility to preserve this tool in FIDE SNPs.

Crosswalk – Transition from MMP to D-SNP

While the proposal to crosswalk members from MMPs to D-SNPs under certain conditions is appreciated, it will only address one period of potential disruption. Member protections and integration elements present today in One Care must have solutions and flexibility to continue in a D-SNP platform. Removing integration flexibilities from existing programs – such as One Care – would be a significant, ongoing disruption.

Enrollee Advisory Committee

We strongly agree with CMS’ emphasis on the importance of enrollee participation in plan governance but encourage CMS to consider ways to ensure such participation is structured to be meaningful and to impact plan accountability to its members. In particular, CMS should require D-SNPs to operate their committees with the accessibility, accommodations, and communication access supports necessary to enable and facilitate meaningful participation by enrollees, including interpreters, accessible transportation, stipends, individualized accessibility accommodations, and technology for remote access. As CMS notes, enrollee advisory committees are already required for Medicaid managed care entities in accordance with 42 CFR 438.110. However, it is unclear whether CMS intends to extend the requirement to the Medicare governance of the organization, or to align Medicare and Medicaid regulatory requirements such that improved governance include both the Medicaid managed care and the D-SNP portions of the member’s plan. Due to the existing requirement in 42 CFR 438.110, we think this requirement does not meaningfully impact FIDE SNPs.

Care Model

One Care’s vision for a person-centered model of care aimed at supporting individuals with disabilities to meet their own needs and goals is integral to the fabric of its design. We encourage CMS to ensure that any barriers – such as potential conflicts with Medicare Model of Care requirements and policy requirements for how D-SNPs implement Medicare covered services and medical necessity requirements – are addressed to allow Massachusetts to continue to advance this approach in support of our members. We further encourage CMS to consider partnering with states in related compliance and monitoring activities to ensure that plans are held to aligned expectations which preserve the fundamental importance of a person-centered model of care.

Health Risk Assessment (HRA)

The proposed 42 CFR 422.101(f)(1)(i) should also provide for states to work with CMS in the development of standardized HRA questions and allow states to require alternative standardized HRA questions in addition to those on CMS’ sub-regulatory list. This would improve alignment with the

Medicaid managed care part of a FIDE SNP and across each states' Medicaid program, and to reduce duplication for members. The resources that will be available to address most members' social determinants of health (SDOH) needs will be localized and may vary from state to state.

Ombudsman and State Health Insurance Assistance Program (SHIP) Funding

We urge CMS to continue making federal funds available for ombudsman programs. Ombudsman programs are a critical support for individual members who experience challenges accessing care and services, as well as an invaluable lens through which CMS and states can better understand how care models and delivery systems function from the member perspective.

Since the inception of One Care, and with strong support from stakeholders, MassHealth has maintained an ombudsman program for members (My Ombudsman (MYO)) using federal grant dollars made available through CMS and administered with support from the Administration for Community Living (ACL). Through a competitive procurement, Massachusetts contracted with a local community-based organization for Ombudsman support and has expanded its scope to also serve all MassHealth members.

MYO serves four primary functions: (1) empowering members by answering questions and providing person-centered education on member rights, benefits, and services; (2) conducting outreach to help raise awareness about One Care and the ombudsman program; (3) assisting members in accessing care, including investigating and resolving complaints; and (4) tracking and reporting to help identify trends and make recommendations for program or policy improvement as appropriate.

Since 2016, MYO has handled over 2,528 complaints and inquiries from One Care members. The types of supports MYO provides ranges from answering basic questions or helping explain written notices, to calling providers' offices, plan services departments, or care managers to investigate issues, to accompanying a member to a care plan meeting to help facilitate communication of the members' needs and options. Evaluation surveys from members who have utilized MYO services rate them highly, and express high rates of satisfaction with services. For example, over the past year, 97% indicated they felt that MYO staff understood their problem well to very well, 97% indicated that they felt MYO staff were knowledgeable to very knowledgeable, and 87% indicated they were satisfied to very satisfied with MYO services.

MYO also serves as an important window into the operations and implementation of One Care and other health plans. For example, MYO and other stakeholders made recommendations to clarify the procedure for beneficiaries to make service requests, which were later incorporated as part of a larger amendment to the One Care contract. MYO also plays a key role in helping the One Care Implementation Council understand member experience, and presents quarterly on the number of complaints received, common complaint topics and examples, and best practices. Further, given MYO's diverse staff composition and mission, MassHealth anticipates that MYO will help advance health equity goals by targeting outreach to members of color and other communities impacted by health disparities.

The ombudsman program is driven entirely by individual, real-time member experience with the program and the plans. Continued federal support of this role is vital, particularly in light of any potential transition from MMP to a D-SNP platform.

Aligned Medicare and Medicaid Incentives and Financing

State Medicaid agencies continue to grapple with fundamental misalignment between Medicare and Medicaid incentives and financing. Effective state investments in community-based services and care coordination for dual eligible members are most likely to result in Medicare, rather than Medicaid, savings. Additional strategies and flexibilities should be developed and pursued to address this long-

standing misalignment, to allow for financial mechanisms and adjustments to address cost-shifting between payers, and to ensure viability of programs serving dual eligible members.

Attainment of the Maximum Out-of-Pocket (MOOP) Limit

Massachusetts appreciates CMS' recognition of long-standing concerns regarding cost shifting to Medicaid based on current calculation of MOOP limits for dual eligible members. While CMS' proposal to count Medicaid crossover payments towards MOOP limits is directionally positive, the financial impact for states, like Massachusetts, that have relatively low Medicare Advantage penetration, may be less beneficial.

Medicare Supplemental Benefits

MassHealth agrees with the intent of the proposed rule to ensure that D-SNPs coordinate supplemental benefits with Medicaid and that Medicare and that the D-SNP is considered as the primary payer when duplicate benefits are offered.

D-SNP-Only MA Contracts

MassHealth supports CMS' intent to enable states to better understand plan financial performance in an integrated environment. The new option for D-SNP-only Medicare Advantage contracts should enhance the ability of states to isolate the integrated plan performance of D-SNPs by removing non-SNP experience from Medicare Advantage plan financials. Although separate Medicare and Medicaid Medical Loss Ratio (MLR) requirements could present an obstacle to full integration, MassHealth appreciates CMS' acknowledgement that states may require plans to report combined Medicare-Medicaid MLRs to allow greater visibility into integrated plan performance.

D-SNP vs. MMP Financing

- *Viability:* Integrated care programs must be financially viable for the state, CMS, and the plans in order to operate. Massachusetts has not previously had D-SNPs serving solely adults with disabilities, so it is not clear what the impact of the bidding and quality payment approach used for D-SNPs will be on the financial performance and sustainability of One Care plans.
- *Rate Setting:* For Medicaid rate-setting, MassHealth sees more flexibility in a traditional managed care rate setting approach than the demonstration rate setting methodology currently used for One Care. Advantages of the Medicaid managed care approach include allowing states to apply an experience-based rate setting methodology (i.e., using encounter data), which should be more accurate than the current FFS equivalency methodology. Moreover, for Medicare financing, under a proposed transition from MMP to D-SNP, One Care plans would be required to submit Medicare bids during rate development, as SCO plans currently do, which could potentially "right size" Medicare's share of One Care capitation rates over time. Nevertheless, MassHealth is concerned that converting One Care plans from MMPs to D-SNPs could negatively impact plan revenue due to the misalignment of the Medicare quality measurement slate with the One Care demonstration population, as discussed above, as well as the treatment of bad debt offsets in plans' Medicare payments.
- *Medicare Shared Savings:* In contrast to our Duals Demonstration 2.0 proposal, D-SNP financing does not offer states the ability to share directly in Medicare savings. CMS has described the MOOP and supplemental benefits proposals as ways for states to shift costs to Medicare, but plans may have less financial room on the Medicare side than CMS anticipates, as discussed above, thus limiting the magnitude of these proposals to meaningfully impact Medicaid financials.

The fundamental financing concern for states is that effective Medicaid investments likely result in Medicare savings. The proposed changes to MOOP and supplemental benefits lean in the opposite direction, but only incrementally. We urge CMS, in collaboration with states, to develop additional strategies and flexibilities to address this long-standing fundamental misalignment and to allow for financial mechanisms and adjustments to address cost-shifting between payers. This might include new approaches and mitigations when MLRs between payers are significantly out of balance. States should be permitted to structure risk mitigation mechanisms that consider combined as well as individual Medicare versus Medicaid profits and losses. Solutions that will be impactful in this space would take a holistic view of how Medicare and Medicaid interact and allow for adjustments based on the full view of cost/savings to effectively serve dual eligible individuals.¹

Quality Measurement

Massachusetts encourages CMS to collect quality data at a level that allows for transparent measurement of the performance of individual products, the identification of health equity and disparities issues, and comparisons between similar populations (such as dual eligible individuals under age 65) across states and Medicare products. We recommend that CMS further ensure that quality measurement is appropriately targeted to the populations served by each product, and that measurement and related financial incentives do not disproportionately penalize D-SNPs for serving populations with more SDOH risk factors.

While CMS does not directly propose changes to quality measurement in the proposed rule, the shift from MMPs to a D-SNP platform could deprive One Care and other MMPs of the quality measurement developed specifically for demonstration populations and eliminate Medicare quality incentive alignment with state-specific, age-appropriate measures.

For example, many of the current star rating measures are medically focused and were designed for older adult populations. These measures may not be as relevant or appropriate for programs targeted to or including the younger disabled adult populations that may be disproportionately impacted by SDOH. Star rating benchmarks are based on performance across Medicare Advantage plans. The differences in populations means that certain benchmarks are inappropriate (too high or too low) for One Care.

The implications for misaligned or inappropriate quality ratings could be substantial for D-SNPs that serve younger dual eligible enrollees. Specifically, because star ratings impact the bonus payments Medicare Advantage/D-SNP plans receive, lower star ratings reduce the pool of funding available for plans to use for supplemental benefits. As a result, D-SNPs serving younger dual eligible enrollees, who represent the most complex and at-risk Medicare members with the highest SDOH impact, may also have less quality bonus funding available. Where CMS has pointed to supplemental benefits as a means for addressing cost shifting concerns, as discussed further below, Massachusetts recommends that CMS ensure the quality measurement strategy that supports these supplemental payments is appropriately tailored to the dual eligible population, including those under the age of 65.

Furthermore, because Medicare contract numbers have historically been assigned at the organization level, star ratings have been measured and assigned based on a combined view of an organization's Medicare Advantage, D-SNP, and Part D Plan products, without distinction for individual products or target populations. Massachusetts has required SCO plans to oversample their enrollees on CAHPS to provide more visibility into SCO product performance, but this approach is administratively burdensome to both the state and the plans. We are pleased that CMS proposes a path to D-SNP specific measurement

¹ Allison Rizer of ATI Advisory described this continued misalignment particularly poignantly in a February 16, 2022 review of the Senate Special Committee on Aging Hearing on Medicare-Medicaid integration earlier this month. Available at [What We Didn't Hear During the Senate Hearing on Dual Eligible Beneficiaries - ATI Advisory](#).

by allowing D-SNPs to have a separate Medicare contract number. However, combining this with the proposed MMPs to D-SNPs transition would, for Massachusetts, shift *which* populations are combined in a single Medicare contract with aggregated star ratings. If One Care plans become D-SNPs, the contracts, star ratings, and other performance information would reflect a combination of an organization's One Care and SCO products (for organizations that operate both products). We recommend maintaining the ability to manage and see reporting at the product level for each of these distinct offerings to allow states and CMS to effectively measure and manage both programs.

Relatedly, on February 2, 2022, CMS released an Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the Advanced Notice). Because the updates proposed in the Advanced Notice relate to our comments on star rating methodologies in these comments, we take this opportunity to briefly address the Advanced Notice. In the Advanced Notice, CMS is considering a variety of options to address variations in performance on certain star rating measures for beneficiaries with Social Risk Factors (SRFs), including:

- Providing stratified reporting by disability, Low Income Subsidy (LIS) status, and dual enrollment;
- Developing a health equity index as a methodological enhancement to the star ratings that summarizes contract performance among those with SRFs across multiple measures into a single score; and
- Replacing the current reward factor added to the overall or summary ratings with the health equity index.

The Advanced Notice's proposal represents a move in the right direction. As CMS continues to explore these options, it should ensure that any proposed changes are not inherently biased against plans that serve younger dual eligible enrollees, where members may experience several co-occurring SRFs. Assessing performance by measure and specific SRF may not address the cumulative impact of co-occurring SRFs and comparing MMPs to other D-SNPs may still place MMPs at a disadvantage with respect to reward scoring.

Administrative and Operational Integration/Alignment

Experience has shown that we can more effectively manage programs serving dual eligible individuals when we have transparency, collaboration, and administrative alignment and simplification between payers. We recommend that CMS build additional resource capacity and establish regulatory provisions enabling it to more fully engage and collaborate with states in all aspects of the management of FIDE SNPs and other coordinated and integrated care programs serving dual eligible individuals.

FIDE SNP Definition

We support the proposed definition updates for FIDE SNP and fully support the proposed requirement for FIDE SNPs to cover Medicaid behavioral health services. Massachusetts has a long-standing commitment and authority to promote a comprehensive continuum of behavioral health services, including diversionary behavioral health services. The explicit goal of the continuum is to reduce avoidable acute inpatient, emergency, and inpatient psychiatric services. For dual eligible individuals, these costs are paid first by Medicare. Thus, savings from the reduction of inpatient and emergency services will be realized by Medicare, not by Medicaid, which impacts the viability of investment in the diversionary services by states. As discussed above, any transition of MMPs to D-SNPs should account for the need to ensure investments and savings align between payers.

Medicaid Authority

Transitioning from MMP to D-SNP authority only addresses Medicare operating authority. States with MMPs would also need to establish separate Medicaid managed care authority in advance of any transition to avoid disruption and gaps. CMS should consider ways to support states in working through Medicaid managed care authorities to assist with any transitions from MMP to D-SNP authority. States will need sufficient time to evaluate Medicaid authority options and obtain such authority, vet policy proposals with stakeholders, make any necessary system (for example, information technology) changes, and conduct procurements, if necessary. Transition planning must consider the time and resources necessary for states to put these pieces in place.

Authorized Representatives

We applaud CMS' intention to recognize any person authorized under state law as an enrollee's representative and believe this will lead to improved member experience and administrative efficiency for states, CMS, and D-SNPs.

Alignment of Governing Rules

We look forward to collaborating with CMS as full partners to operating truly integrated programs for dual eligible individuals. For MMP to D-SNP transitions, we have found the level of joint management to be largely beneficial in effective oversight and problem-solving for One Care. By contrast, for SCO, we have found it challenging at times to get traction when raising program issues and finding productive, permissible ways to partner with CMS to improve oversight and make processes more efficient. We urge CMS to consider ways to preserve effective aspects of partnerships with states, and, in particular, to resource and empower the Medicare-Medicaid Coordination Office to collaborate with states in the operation of D-SNPs and PACE Programs.

We appreciate areas where CMS proposes incremental or full alignment between Medicare and Medicaid regulatory requirements, but we also continue to encourage CMS to reconsider its approach to setting separate requirements for D-SNPs and Medicaid managed care, which will be an ongoing barrier to integration.

CMS is proposing modest, incremental updates to regulations for D-SNPs, and specifically for FIDE SNPs. However, organizations operating FIDE SNPs must still comply with overlapping and, at times, conflicting requirements in Medicare Advantage regulations and Medicaid managed care regulations. As a result, state Medicaid agencies must continually navigate and reconcile these conflicts and gaps for products that serve their dual eligible members. This imposes an administrative burden and cost for both states and plans.

A better, more rational, more impactful, and more effective approach would be for CMS to align its regulations for D-SNPs - and for FIDE SNPs in particular - with those that already exist in Medicaid managed care rules and have rulemaking space that specifically addresses both the Medicaid and Medicare statutory and regulatory requirements for integrated products. Because D-SNPs only serve dual eligible members, these individuals, by definition, will be in delivery systems subject to two sets of regulations. It is perplexing that CMS declines to go further in its rulemaking for products serving dual eligible members to address the conflicts in governance. Without this aligned, reconciled view, integration will remain elusive.

CMS should collaborate with states to develop a truly integrated regulatory or other governing framework that aligns Medicaid managed care and D-SNP requirements into one clear set of governing rules to effectively oversee integrated programs for dual eligible individuals. Additional approaches that CMS could consider to better address continued integration barriers include:

- CMS could layer 1115A demonstration authority on top of the D-SNP platform to facilitate further integration, alignment, and member-protections.
- CMs could identify an additional level of integration for D-SNPs beyond FIDE SNPs (for example: Comprehensive Aligned and Integrated D-SNPs) and work through both the Medicare Advantage and Medicaid managed care regulatory processes to develop unified regulations that fully align requirements between Medicare and Medicaid for the most integrated type of plans serving dual eligible members.
- CMS could continue to partner with states seeking to drive innovation forward by developing and testing new and advanced strategies for serving dual eligible members through 1115A demonstration authority.
- CMS could give state stakeholders clear avenues to engage directly with CMS on the implementation and operation of integrated care programs serving dual eligible individuals. Our stakeholders are a valuable and committed resource for innovation and policy development, and One Care is a much better program for their engagement with us and CMS throughout the design and operation phases.

Conclusion

Massachusetts is committed to meeting the needs of its dual eligible members and has made significant progress with integration, first through D-SNPs, and then through MMPs designed to meet the needs of younger adults with disabilities. Any transition for MMPs to D-SNPs should be preceded by careful, deliberative planning in partnership with states, and should take into consideration numerous additional flexibilities and innovations need mechanisms to ensure they can continue and advance through any new platform. **We appreciate CMS taking incremental steps forward and strongly urge CMS to ensure that helping other states advance does not undo important progress that has impacted the lives of so many of our members in Massachusetts.** We encourage CMS to keep additional integration options in the toolbox for states seeking to create more responsive, person-centered, high-quality integration approaches for dual eligible individuals.

Thank you for the opportunity to comment on these important policy proposals.

Sincerely,



Amanda Cassel Kraft
Assistant Secretary for MassHealth and Medicaid Director

cc: Marylou Sudders