



March 7, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

Arnold Ventures welcomes the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the “Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs” proposed rule (CMS-4192-P) that was published in the Federal Register on January 12, 2022.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work within the health care sector is driven by a recognition that the system costs too much and fails to adequately care for the people it seeks to serve. Our work spans a wide range of issues including commercial-sector prices, provider payment incentives, prescription drug prices, and complex care.

First, we want to thank you for the agency’s important work to help improve the Medicare Advantage (MA) and Prescription Drug Benefit programs. We recognize the high volume of comment letters that you will receive and the competing priorities the team is facing and appreciate the opportunity to provide input.

Our work to date on complex care has centered on addressing the needs of the dual-eligible population, who use more care and experience worse outcomes compared to their Medicare-only counterparts. One of the key drivers of their higher program spending and poor outcomes is the fragmentation between the financing and delivery of Medicare and Medicaid benefits.

In recognition of this problem, in May 2021 we wrote you a [letter](#) outlining potential pathways to improve care and coverage for the dual-eligible population by applying lessons from the Medicare-Medicaid plans (MMPs) under the Financial Alignment Initiative (FAI) demonstration to the Medicare Advantage program, more specifically to Dual-Eligible Special Needs Plans (D-SNPs). With improvements, D-SNPs have the potential to offer an effective pathway to expand beneficiaries’ access to integrated Medicare-Medicaid models. With this rule, CMS has proposed several such improvements and we are supportive of its overarching direction, which seeks to increase the level of integration between Medicare and Medicaid through D-SNPs. In particular, we are supportive of CMS’ requirement that D-SNPs adopt and include consumer advisory committees, behavioral health, physical health, and long-term care benefits, overlapping Medicare and Medicaid services areas, and exclusively aligned enrollment.



However, while CMS is raising the bar on the level of integration required to be considered a D-SNP, the proposed rule does not provide additional education to help beneficiaries understand their choices or further curb D-SNP look-alike plans. We are concerned that leaving the door open for D-SNP look-alikes threatens to undermine progress on integration, leading to the erosion of D-SNP enrollment over time and additional beneficiary confusion.

The below chart summarizes our comments and what follows are more details regarding our feedback.

| Provision | Comment |
|--|---|
| Enrollee Participation in Plan Governance | We applaud the effort to facilitate beneficiary feedback and urge CMS to more explicitly identify its expectations for the committees. |
| Exclusively Aligned Enrollment for FIDE SNPs | We support the requirement that all FIDE-SNPs use exclusively aligned enrollment. We also support limiting FIDE-SNPs to full-benefit dual-eligible individuals but encourage CMS to study the impact of integrated models on the partial-benefit dual-eligible population. |
| Capitation for Medicare Cost-Sharing for FIDE SNPs and Solicitation of Comments for Applying to Other D-SNPs | We support CMS' requirement that FIDE-SNPs cover cost-sharing for enrollees and urge the agency to further require that all D-SNPs do the same. |
| Scope of Services Covered by FIDE SNPs & Medicaid Carve-Outs and FIDE SNP and HIDE SNP Status | We support CMS' requirement that FIDE-SNPs offer a fully-integrated set of benefits and the agency's proposal to limit the allowance of benefit carve-outs. |
| Service Area Overlap Between FIDE SNPs and HIDE SNPs and Companion Medicaid Plans | We support the proposed requirement that FIDE-SNPs and HIDE-SNPs have an overlapping service area with their affiliated Medicaid managed care organization and encourage CMS to extend this requirement to all D-SNPs that operate in the same area as a Medicaid managed care plan. We also suggest that CMS educate beneficiaries ahead of this change. |
| Limiting Certain MA Contracts to D-SNPs | We support requiring D-SNPs to operate their own contract and encourage CMS to ensure that plans are given adequate time to comply. We also urge CMS to mandate this contract |



| | |
|---|---|
| | change for all D-SNPs. |
| Integrated Member Materials & Joint State/CMS Oversight | We support CMS' proposal to codify and outline its process for collaborating with states to support further integration and urge CMS not to restrict this collaboration to plans with exclusively aligned enrollment or the existence of a separate contract. |
| Comment Solicitation on Financing Issues | We encourage CMS to consider pathways to mandate integrated MLR requirements on D-SNP either directly, or through states. In addition, we encourage CMS to continue exploring opportunities for states to share in any savings generated under FIDE-SNPs. |
| Definition of Applicable Integrated Plan Subject to Unified Appeals and Grievances Procedures | We support the expansion of the integrated appeals and grievance process. |
| Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees | We support CMS providing beneficiaries with more clarity at the point of enrollment, in particular regarding TPMOs. |
| Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data | We support CMS providing additional transparency around the MLR, including the requirement that plans publicly report on supplemental benefit spending. |
| Additional comments | |
| This proposed rule takes a number of important steps toward ensuring transparency and clarity around enrollment. However, more work is needed to increase awareness around integrated options and their potential value, including amending Plan Finder and its educational resources. | |
| We are extremely supportive of the various efforts to increase D-SNPs standards. However, without increasing the limits placed on D-SNP look-alikes, we are concerned that plans will circumvent the requirements for serving dual-eligible individuals under integrated care and general MA plans or other types of SNPs will pursue dual-eligible individuals. We urge CMS to tamp down on the targeting of dual-eligible individuals by non-integrated models. | |

II. A. 3. Enrollee Participation in Plan Governance (§ 422.107)

Background: The proposed rule would require all D-SNPs to establish a consumer advisory committee. This was a requirement of MMPs under the Financial Alignment Initiative demonstration and intended to ensure a baseline level of direct beneficiary feedback. The



proposal requires that each advisory committee include a reasonably representative sample of individuals enrolled in the D-SNP and solicit input on opportunities to improve access to covered services, coordination of services, and health equity for underserved communities. However, CMS does not specify how plans should meet these requirements—for example, the number of meetings, the specific topics plans must cover, or how plans must incorporate committee feedback.

Policy Position: One of the goals of Medicare-Medicaid integration is a health care delivery system that puts the person rather than the program at the center. Beneficiary input is critical to ensuring that programs and systems are designed with beneficiaries' needs and preferences in mind. As such, we applaud the inclusion of a provision to facilitate beneficiary feedback. However, we urge CMS to be more explicit with its expectations for these groups, including defining the criteria that create a reasonably representative sample, requiring organizations to implement best practices to ensure retainment and equity, and clarifying how MA organizations will be held accountable for adhering to the requirements included within this provision.

Justification: As the proposed rule lays out, advisory committees can serve as valuable beneficiary protections that help identify the issues they face and ensure that their feedback is heard. However, the establishment of an advisory committee alone will not achieve these ends. Evaluations of MMP advisory committees, for example, find that despite requirements in most states that committee membership reflects the diversity of the member body, the lack of guidance on what diversity means or how to properly recruit leads to under-representation in committees. For example, committees tend to have few members who live in nursing homes or assisted living facilities, and members who are over 65, Asian, or Native American tend to be underrepresented.¹

MMP evaluations also find that advisory committees benefit from adopting best practices for inclusion, such as training members on their role of providing input, jointly setting agendas with members, and providing transportation support, food, or other accommodations for meetings.² Participants in advisory committees also recommend that advisory committees regularly report on how feedback is being incorporated into plan practices and programs, thereby closing the feedback loop. When members are expected to share their struggles without being informed of whether and how their feedback is incorporated, they get frustrated, burnt out, and often leave the committees.³ Because they are not required to do so, many advisory committees do not use best practices today and their output is less meaningful and productive as a result.

¹ Center for Consumer Engagement in Health Innovation (2019). An Exploration of Consumer Advisory Councils within Medicare-Medicaid Plans Participating in the Financial Alignment Initiative.
https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-Report_Final.pdf.

² Center for Consumer Engagement in Health Innovation (2019). An Exploration of Consumer Advisory Councils within Medicare-Medicaid Plans Participating in the Financial Alignment Initiative.
https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-Report_Final.pdf.

³ Center for Consumer Engagement in Health Innovation (2019). An Exploration of Consumer Advisory Councils within Medicare-Medicaid Plans Participating in the Financial Alignment Initiative.
https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-Report_Final.pdf.



One method to increase accountability is to ensure that representatives from state agencies overseeing programs for people who are dual eligible are present at beneficiary advisory committee meetings. When states hear grievances directly from members it provides additional fodder for them to advocate for necessary changes and improvements. State participation in advisory committees has the added benefits of ensuring that states can hold all plans equally accountable and allowing for the sharing of best practices across plans within the same state. Another method is direct CMS oversight, to ensure that D-SNPs adhere to the guidance outlined in this proposed rule and establish and maintain advisory committees that meaningfully empower beneficiaries and elevate their voices.

II. A. 5. a. Refining Definitions for Fully Integrated and Highly Integrated D-SNPs - Exclusively Aligned Enrollment for FIDE SNPs (§ 422.2 and 422.107)

Background: CMS proposes that beginning in 2025, all FIDE-SNPs be required to implement exclusively aligned enrollment, meaning that they can only enroll dual-eligible individuals who receive their Medicaid benefits from a plan offered by the same parent company as the D-SNP. CMS also proposes limiting FIDE-SNPs to full-benefit dual-eligible individuals.

Policy Position: We support requiring exclusively aligned enrollment for all FIDE-SNPs and believe alignment between Medicare and Medicaid is an essential component of any truly integrated model. We support limiting FIDE-SNPs to full-benefit dual-eligible individuals but encourage CMS to study the impact of integrated models on partial-benefit dual-eligible individuals, especially those who develop long-term care needs.

Justification: We see mandating exclusively aligned enrollment for FIDE-SNPs as crucial to increasing integration between Medicare and Medicaid coverage. We believe that FIDE-SNPs should exist to fully integrate the full range of Medicare and Medicaid benefits, as their name suggests. If they do not provide this service, the value of a FIDE-SNP compared to other forms of D-SNPs is in question. Furthermore, FIDE-SNPs should help simplify beneficiary decision-making and make navigating plan processes easier. Choosing a FIDE-SNP means selecting a plan that coordinates *both* Medicaid and Medicare coverage; there is no need to select separate coverage options for Medicaid and Medicare.

Additionally, we believe that the people who most benefit from full Medicare and Medicaid integration under a model like FIDE-SNP are those who receive Medicare and the full range of Medicaid benefits and services (i.e., full-benefit dual-eligible individuals). However, we recognize that there is fluctuation in eligibility status within dual-eligibility and that partial-benefit dual-eligible individuals sometimes acquire full-benefit dual-eligibility,⁴ especially due to long-term care needs. We are interested in funding additional research to study this phenomenon

⁴ ATI Advisory (2021). Advancing the Policy Environment to Address the Unique Needs of Partial Dual Eligible Beneficiaries. <https://atiadvisory.com/wp-content/uploads/2021/06/Advancing-the-Policy-Environment-to-Address-the-Unique-Needs-of-Partial-Dual-Eligible-Beneficiaries.pdf>.



and the value of integrated care for partial dual-eligible individuals. We encourage CMS to do the same—assess whether integrated models can help prevent partial-benefit dual-eligible individuals from necessitating full-benefit status, and keep findings in mind when contemplating the future availability of the D-SNP model for partial-benefit dual-eligible individuals.

II. A. 5. b. Refining Definitions for Fully Integrated and Highly Integrated D-SNPs - Capitation for Medicare Cost-Sharing for FIDE SNPs and Solicitation of Comments for Applying to Other D-SNPs (§ 422.2 and 422.107)

Background: CMS proposes that FIDE-SNPs be required to cover, and all other D-SNPs be encouraged to cover, Medicare cost-sharing, including coinsurance, copayments, and deductibles.

Policy Position: We support CMS' requirement that FIDE-SNPs cover cost-sharing for enrollees and urge the agency to further require that all D-SNPs do the same.

Justification: Requiring that all D-SNPs cover cost-sharing for full-benefit dual-eligible individuals provides the minimum level of integration for dual-eligible individuals and the providers who serve them. It consolidates coverage for all Medicare-covered services with the D-SNP, including any fees associated with the service and any cost-sharing that would otherwise be paid by the beneficiary if they did not have full-benefit Medicaid coverage. Additionally, requiring all states to actively engage in more robust contracting than is required today may lead more states to contemplate establishing integrated models, leading to increased access. Consolidating cost-sharing within D-SNPs may also improve dual-eligible individuals' access by assuring providers that they will be adequately compensated for their services. However, we recognize that adhering to this requirement may be a challenge for states and believe that CMS should provide states with both an adequate amount of time and support to implement this requirement.

II. A. 5. c. & e. Refining Definitions for Fully Integrated and Highly Integrated D-SNPs - Scope of Services Covered by FIDE SNPs (§ 422.2 and 422.107) & Medicaid Carve-Outs and FIDE SNP and HIDE SNP Status (§ 422.2 and 422.107)

Background: CMS proposes that FIDE-SNPs be responsible for the following three benefits, to extent that they are made available by the states in which they operate:

1. All primary and acute care services,
2. All Medicaid home health services, as defined in § 440.70 and DME services, as defined in §440.70(b)(3), and
3. All behavioral health services covered by the Medicaid program.

These benefits would be required to be covered in addition to the cost-sharing requirements described previously and the nursing home requirements outlined in previous rulemaking.



CMS also proposes to permit limited LTSS and behavioral health carve-outs, which must be approved by CMS and must only impact a minority of eligible individuals or constitute a small portion of the scope of services.

Policy Position: We believe that mandating that FIDE-SNPs be responsible for the full range of benefits a dual-eligible is entitled to, with limited carve-outs, is essential to meeting the definition of integration. Thus, we are fully supportive of raising the bar on FIDE-SNPs by requiring them to offer a fully-integrated set of benefits, inclusive of traditional medical services, home- and community-based services, institutional services, and behavioral health services. We are also supportive of CMS limiting the allowance of and increasing oversight over carve-outs.

Justification: Accessing the full range of covered benefits from one entity is central to the integrated care experience for dual-eligible individuals. MMP evaluations find that the factors that most contribute to beneficiary satisfaction include the experience of having a simplified coverage model.⁵ Moreover, dual-eligible individuals stand to benefit immensely from the inclusion of behavioral health benefits and LTSS within integrated coverage. With over 40% of dual-eligible individuals experiencing at least one mental health condition⁶ and 70% of dual-eligible individuals reporting long-term care need,⁷ streamlined access to behavioral health and LTSS is critical for this population. Analysis of the MMPs reinforces this importance, identifying behavioral health services as one of the most important factors associated with beneficiary satisfaction.⁸ However, we do believe it is important that limited and specialized carve-outs be permitted to continue as deemed appropriate by states and CMS.

II. A. 5. f. Refining Definitions for Fully Integrated and Highly Integrated D-SNPs - Service Area Overlap Between FIDE SNPs and HIDE SNPs and Companion Medicaid Plans (§ 422.2 and 422.107)

Background: CMS proposes to require that by 2025, FIDE-SNPs and HIDE-SNPs must cover the entire service area covered by their aligned Medicaid managed care organization. In cases where the service areas do not align, the plan would be considered a D-SNP only, and would lose FIDE or HIDE status. Today, all FIDE-SNPs and most HIDE-SNPs already meet this criterion.

⁵ RTI International on behalf of CMS (2018). Financial Alignment Initiative California Cal MediConnect: First Evaluation Report. <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>.

⁶ CMS (2020). People Dually Eligible for Medicare and Medicaid. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

⁷ Kaiser Family Foundation (2015). Serving Low-Income Seniors Where they Live: Medicaid's Role in Providing Community-Based Long-Term Services and Supports. [https://files.kff.org/attachment/issue-brief-serving-low-income-seniors-where-they-live-medicare-rol-in-providing-community-based-long-term-services-and-supports#:~:text=Almost%20seven%20in%20ten%20dual,of%20need%20\(Figure%203\).](https://files.kff.org/attachment/issue-brief-serving-low-income-seniors-where-they-live-medicare-rol-in-providing-community-based-long-term-services-and-supports#:~:text=Almost%20seven%20in%20ten%20dual,of%20need%20(Figure%203).)

⁸ RTI International on behalf of CMS (2018). Financial Alignment Initiative California Cal MediConnect: First Evaluation Report. <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>.



To reduce disruptions, CMS proposes allowing plans losing their HIDE-SNP status to crosswalk members into a D-SNP owned by the same parent company. CMS is also considering an alternative requirement which would mandate that FIDE-SNPs and HIDE-SNPs have a certain percentage of enrollment or service area overlap with their affiliated Medicaid plan in order to maintain their FIDE or HIDE status.

Policy Position: We urge CMS to finalize the proposed requirement that FIDE-SNPs and HIDE-SNPs have an overlapping service area with their affiliated Medicaid managed care organization. We also encourage CMS to extend this requirement to *all* D-SNPs that operate in the same area as a Medicaid managed care plan. Additionally, we suggest that in the years prior to the proposed change, CMS work with beneficiary advocates and states to ensure that enrollees are aware of the change before it goes into effect.

Justification: D-SNPs exist to provide tailored coverage to dual-eligible individuals exclusively. We believe a central component of this tailored coverage should be coordination with Medicaid coverage to the greatest extent feasible under existing state laws. Service area alignment is critical to creating this environment. When a state contracts with at-risk entities to provide Medicaid coverage to the dual-eligible population, D-SNPs should be permitted to operate only if they have one of these contracts. We believe that CMS should use its authority as an active purchaser to deny contracts to plans that lack such a contract, unless a state requests an exception and such exception facilitates the provision of integrated coverage to dual-eligible individuals. The allowance of D-SNPs to compete alongside other D-SNPs where integration is possible only serves to confuse beneficiaries and degrade the definition of a D-SNP.

While these proposed changes may cause disruptions in coverage in the short term, we believe the disruptions can be mitigated through adequate education and support. Further, we believe that the policy will create a better beneficiary experience in the long term. We recommend that ahead of the rule's effective date, CMS execute a beneficiary outreach program for dual-eligible individuals and their support networks regarding the impending changes. In addition, CMS could consider creating an exception process to grandfather in enrollees who wish to remain in unaligned plans. However, once the rule goes into effect, we hold that D-SNPs should not be able to offer plans in areas where they lack a Medicare managed care contract, assuming that the state includes such an option.

II. A. 6. a. Additional Opportunities for Integration Through State Medicaid Agency Contracts - Limiting Certain MA Contracts to D-SNPs (§ 422.107)

Background: CMS proposes to codify states' ability to require MA organizations to establish separate D-SNP-only contracts in the instance that a state is using exclusively aligned enrollment. CMS believes this can provide states that employ this strategy with increased plan performance and financial transparency, which can be difficult to achieve when the D-SNP is included under a contract with multiple types of MA plans. The proposed rule specifies that MA



sponsors would be able to use a new crosswalk exception to seamlessly transition members into D-SNP-only contracts in the instance that a state employs this approach.

Policy Position: We are supportive of efforts to require D-SNPs to operate their own contract, but believe that CMS should mandate this for *all* D-SNPs, rather than allowing states to assert this requirement. At the same time, we encourage CMS to set this deadline far enough in the future so that it can contemplate what changes, if any, are needed to the quality rating or other systems, in line with this change.

Justification: Today, due to the fact that contracts include a multitude of MA plan types, there is a lack of transparency around the plan performance and financial behavior of specific MA plans, including D-SNPs. MedPAC's June 2020 report highlights this issue, noting that comparing performance among groups with different characteristics and needs can mask disparities in plan performance.⁹ MedPAC's findings demonstrate the need for distinct plan types to be measured separately. CMS' proposed rule establishes a framework for separate measurements by segregating D-SNPs from other MA plan types in contracting, thereby allowing for a clearer assessment of D-SNP performance and financial behavior.

II. A. 6. b & c. Additional Opportunities for Integration Through State Medicaid Agency Contracts - Integrated Member Materials & Joint State/CMS Oversight (§ 422.107)

Background: CMS proposes to allow states to require, through their State Medicaid agency contracts (SMACs), that certain D-SNPs with exclusively aligned enrollment use integrated documentation, including an integrated summary of benefits, formulary, and combined provider and pharmacy directory. CMS is also considering including evidence of coverage and annual notice of change documentation within this provision and notes that states would be permitted to integrate materials beyond those that are explicitly listed in the final rule. For all integrated materials, states would be able to participate in their review and approval.

In the instance that a state mandates exclusively aligned enrollment, CMS also proposes to increase coordination of review and oversight of D-SNPs by codifying the following opportunities:

1. Allowing state Medicaid officials to use the CMS Health Plan Management System (HPMS) for oversight and information sharing with CMS, and
2. Coordinating with state Medicaid officials on program audits.

Policy Position: We support CMS' proposal to outline and codify its process for collaborating with states to further integrate the Medicare and Medicaid programs for dual-eligible individuals. However, we do not think these opportunities should be solely dependent on exclusively aligned enrollment or the existence of a separate contract (assuming that CMS does not move forward

⁹ MedPAC (2020). June 2020 Report to Congress - Chapter 3: Replacing the Medicare Advantage Quality Bonus Program. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf.



with our recommendation to mandate that all D-SNPs operate on their own contract). We believe empowering states with information on the D-SNPs operating in their states will enable them to implement integrated models more thoughtfully.

Justification: One set of materials and a coordinated plan review and oversight process are two of the hallmark features of the MMPs. We see both of these components as central to an integrated experience for the beneficiary as well as for the organizations that seek to operate these products. It is well documented that without this coordination, they are inundated with materials that they often do not know how to make sense of. A recent report by Arnold Ventures on the experiences of dual-eligible enrollees in integrated models found that beneficiaries are overwhelmed by the number of materials they receive and confused by the fact that they come from different sources.¹⁰ Integration of member materials reduces this confusion and helps dual-eligible individuals to feel as if they are enrolled in one plan, rather than two.

II. A. 6. d. Additional Opportunities for Integration Through State Medicaid Agency Contracts - Comment Solicitation on Financing Issues (§ 422.107)

Background: CMS seeks feedback on tactics to apply certain MMP financial methodologies to D-SNPs, including:

1. Integrated medical loss ratios (MLRs) - CMS does not believe that it has the statutory authority to require Medicaid costs and revenue be included within the Medicare MLR requirement. However, it suggests that states may have authority to require an integrated MLR as part of their contracts with D-SNPs.
2. Considering the Medicare expenses and covered benefits in Medicaid rate-setting - CMS seeks input on whether considering the impact of Medicare-covered benefits on costs and utilization of Medicaid services advances integration goals and adheres to requirements around actuarial soundness.

Policy Position: We want to see Medicare and Medicaid financing integrated. An integrated MLR is part of a comprehensive approach to financial integration. As such, we encourage CMS to look for ways to mandate integrated MLR requirements on D-SNP either directly on the plans themselves or indirectly by requiring the inclusion of integrated MLR in the state Medicaid contract. In addition, we encourage CMS to continue exploring opportunities for states to share in any savings generated under FIDE-SNPs. We also encourage CMS to ensure that this guidance does not lead to cost-shifting across programs.

Justification: Financial alignment is a critical component of achieving full integration of Medicare and Medicaid. A truly integrated model uses one pot of dollars to cover beneficiaries' services and needs. Lack of financial alignment not only complicates the care experience, but incentivizes cost-shifting. Additionally, the federal government, states, and the integrated plan should be able to share in any savings generated. A hallmark of the MMP was a three-way

¹⁰ Arnold Ventures (2022). Findings from Arnold Ventures' Request for Information on the Dual-Eligible Experience. https://craftmediabucket.s3.amazonaws.com/uploads/AVcomplexcareRFI_findings_v3.pdf.



contract that aligned financial incentives across these three entities. The rule as proposed, however, does not allow the same level of alignment within the FIDE-SNP model.

We urge CMS to consider what authority it does have, either directly, or through states, to move the FIDE-SNP model towards financial alignment, including relying on one pot of dollars, promoting shared savings, and aligning financial oversight (e.g., through an integrated MLR).

II. A. 7. Definition of Applicable Integrated Plan Subject to Unified Appeals and Grievances Procedures (§ 422.561)

Background: CMS proposes to expand the types of D-SNPs that are required to have a unified grievance and appeals process from FIDE-SNPs and HIDE-SNPs with exclusively aligned enrollment only, to all D-SNPs that enroll beneficiaries who receive their Medicaid managed care benefits through an affiliated Medicaid managed care plan that shares a parent organization with the D-SNP and includes cost-sharing and primary and acute care, as well as at least one of a number of other long-term care services.

Policy Position: We support this expansion to the integrated appeals and grievance process.

Justification: Absent mandates to align grievance and appeals processes, dual-eligible individuals must navigate two sets of rules and protections related to levels of appeal, review entities, timelines, and decisions. For obvious reasons, this creates great burden and confusion for dual-eligible beneficiaries, especially when it comes to services covered by both Medicare and Medicaid. Expanding the number of plans that are required to integrate their grievance and appeals process will reduce the burden for dual-eligible beneficiaries and increase meaningful access and use of this important protection mechanism.

II. F. Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees (§ 422.2260, 423.2260, 422.2267, and 423.2267)

Background: In an effort to better support beneficiaries in navigating their plans, CMS proposes changes to the MA marketing and communications requirements. Of particular interest, CMS proposes to increase regulatory oversight over third-party marketing organizations (TPMOs), including by defining TPMOs and standardizing the TPMO disclaimer to clarify that these groups do not provide information on the entire universe of available options and point beneficiaries toward official Medicare resources.

Policy Position: We support CMS' efforts to provide beneficiaries with more clarity at the point of enrollment, in particular regarding TPMOs.

Justification: Analyses of the experience of dual-eligible individuals within integrated models consistently find that beneficiaries require more transparency and support in parsing coverage options and navigating plans once enrolled. Consistent with previous research, AV's own report



on beneficiary experience identified a need for improved translation of educational and member materials.¹¹ This report also highlighted significant confusion surrounding plan marketing. As CMS notes, TPMOs often distract or mislead beneficiaries, in some cases, pulling them away from options that would better serve their needs. We believe CMS' proposed requirements would help distinguish TPMOs from neutral navigation supports and allow beneficiaries to make more informed coverage decisions.

II. G. Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data (§ 422.2460, 422.2490, and 423.2460)

Background: The April 2018 final rule reduced MA's MLR reporting requirements to include only the amount of remittance due to beneficiaries. Given the limitations to this approach, including the inability to verify accurate calculation of a contract's MLR, CMS proposes to reinstate the detailed MLR reporting requirements that existed prior to the 2018 rule and resume public release of Medicare Part C and Part D data.

CMS also proposes to require MA organizations to publicly report spending on a variety of categories of supplemental benefits to increase accountability for accuracy in the calculation of the MLR.

Policy Position: We support CMS' efforts to provide additional transparency around the MLR, including the requirement that plans publicly report on supplemental benefit spending.

Justification: MA organizations use taxpayer dollars to provide Medicare coverage to eligible beneficiaries. As such, we believe CMS and the public have the right to information about how and where those dollars are spent. Therefore, we believe that the MLR requirements are an important component of plan accountability. To the extent that requiring additional reports would assist with CMS' oversight of these requirements and provide information to help assess the value of supplemental benefits provided to MA enrollees, we are supportive of this data collection effort. We also encourage CMS to contemplate ways to strengthen the existing requirements to address tactics used by plans to subvert the MLR requirements.

Additional Comments Not Addressed within the Proposed Rule

We believe that individuals who are dually eligible for Medicare and Medicaid benefit from enrollment in plans that integrate the two programs. Unfortunately, between the excessive number of options available and the cacophony of information provided, the coverage landscape is overwhelming for dual-eligible individuals, making it difficult for them to identify, select, and enroll in integrated models. Reinforcing previous findings to this effect, AV's recent report on dual-eligible individuals' experiences emphasized the challenges associated with the current enrollment landscape, highlighting advocate calls for increased support for beneficiaries

¹¹ Arnold Ventures (2022). Findings from Arnold Ventures' Request for Information on the Dual-Eligible Experience. https://craftmediabucket.s3.amazonaws.com/uploads/AVcomplexcareRFI_findings_v3.pdf.



struggling to understand their integrated coverage options, including the potential benefits associated with enrolling in these models. This proposed rule takes a number of important steps toward ensuring transparency and clarity around enrollment, however, more work is needed to increase awareness around integrated options and their potential value. An effective next step would be to contemplate ways to amend Medicare Plan Finder and its educational resources to make the value of integrated models clearer. We suggest using My Care, My Choice as a template for this effort. CMS could additionally consider notifying dual-eligible enrollees when they select a model that does not integrate care if one is available to them, as well as requiring all non-integrated coverage options (including FFS) to notify dual-eligible beneficiaries through disclaimers in beneficiary-facing materials that their Medicaid coverage is provided elsewhere.

Another area for additional attention is the potential targeting of dual-eligible individuals by non-integrated plans. We strongly support the various ways in which this proposed rule raises the bar on D-SNPs. However, without increasing the limits placed on D-SNP look-alikes, we are concerned that plans will circumvent the requirements for serving dual-eligible individuals under integrated care and target dual-eligible individuals under general MA plans or other types of SNPs, including C-SNPs and I-SNPs. This has the potential to undercut true integration. We urge CMS to couple important improvements to the D-SNP model provisions with greater efforts to tamp down on the targeting of dual-eligible individuals by non-integrated models, including by (1) reducing the threshold for declining to contract or renew contracts with D-SNP look-alikes from 80 to at least 50 percent and (2) contemplating requiring Medicare to inform beneficiaries when they are enrolling in a non-integrated model where an integrated model exists.

Conclusion

Arnold Ventures is prepared to assist with any additional information needed. Please contact Arielle Mir at amir@arnoldventures.org with any questions related to complex care and our comments about integrated coverage for the dual-eligible population. Thank you again for the opportunity to comment and your consideration of the above.

Mark Miller