



January 5, 2024

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 2025 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; Health Information Technology Standards and Implementation Specifications” proposed rule (CMS-4205-P) that was published in the Federal Register on November 15, 2023.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. We work to develop evidence to drive reform across a range of issues including health care, education, and criminal justice. 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 serves.

First, we want to thank the agency for its important work to help improve the MA and Prescription Drug Benefit programs. We recognize the high volume of comment letters that you will receive and the competing priorities you are facing and appreciate the opportunity to provide input.



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

Provision	Comment
Additional Changes to an Approved Formulary – Substituting Biosimilar Biological Products	We support the CMS proposal to include substitutions of biosimilar biological products other than interchangeable biological products for their reference products as maintenance changes. This change would make the process for substituting biosimilars for their reference biologics more streamlined for Part D plans and would promote greater access to biosimilar products amongst patients.
Standardizing the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Appeals Process	We support CMS's efforts to streamline the RADV appeals process and encourage CMS to consider larger scale reforms to reduce substantial overpayments to MA plans and recoup improper payments.
Mid-Year Enrollee Notification of Available Supplemental Benefits	We appreciate the initial steps that CMS is taking to improve transparency of supplemental benefits in the MA program by requiring MA plans to notify enrollees mid-year of their unused supplemental benefits. We encourage CMS to take additional action to increase data and transparency on supplemental benefits to improve oversight and accountability and evaluate the value of benefits provided to beneficiaries.
Enhance Guardrails for Agent/Broker Compensation	We strongly support CMS in its efforts to promote fair and competitive Medicare markets by taking steps to better align compensation incentives with the goal of providing accurate and unbiased enrollment guidance to beneficiaries. We suggest that CMS consider ways to further align agent/broker compensation incentives between MA plans and Part D plans in traditional Medicare and build on recent actions to regulate MA marketing practices and protect beneficiaries from deceptive tactics in future rulemaking.
Special Enrollment Period changes for people who are dual-eligible those with a low-income subsidy	We support CMS' recommendation to revise the SEP for the dual-eligible population and those with a low-income subsidy to once-per-month into traditional Medicare and a stand-alone PDP or an integrated D-SNP. We also encourage CMS to modify the



	Medicare SEP enrollment effective date to allow alignment with Medicaid enrollment effective dates.
Enrollment Limitations for Non-Integrated Medicare Advantage Plans – Services area and Plans	We are supportive of CMS’ proposal to limit MAOs to one D-SNP offering per service area where the MAO operates a Medicaid MCO. We also support an exception process for states as outlined in the proposed rule. In addition, we strongly encourage CMS to consider not signing a contract with D-SNPs in service areas where an integrated D-SNP (e.g., FIDE-SNP or HIDE-SNP) is offered, unless a state asks for an exception as part of its program design.
Enrollment Limitations for Non-Integrated Medicare Advantage Plans – Exclusively Aligned Enrollment	We strongly support CMS’ proposal to align enrollment between integrated D-SNPs and Medicaid MCOs. However, we encourage CMS to implement a limited exception process for states that allow carve-outs and Medicaid fee-for-service to compete alongside Medicaid MCOs.
Reducing Threshold for Contract Limitation on D-SNP Look-Alikes	We support CMS’ proposal to decrease the D-SNP look-alike threshold for non-SNP plans and encourage CMS to reduce the threshold to 50%.
Expanding Permissible Data Use and Data Disclosure for MA Encounter Data	We support expanding states’ access to and early use of MA encounter data to better coordinate care services for the dual-eligible population.
For D-SNP PPOs, Limit Out-of-Network Cost Sharing	We are supportive of CMS’ proposal to limit D-SNP PPO cost-sharing.
Comment Solicitation: Medicare Plan Finder and Information on Certain Integrated D-SNPs	We recommend that Medicare Plan Finders’ default display list integrated D-SNPs first for people who are dual-eligible. We additionally recommend that Medicare Plan Finder display a more complete picture of the benefits available through D-SNPs, including the supplemental Medicaid benefits that the beneficiary would receive if enrolled in an affiliated Medicaid managed care organization contract.



III. F. Additional Changes to an Approved Formulary — Biosimilar Biological Product Maintenance Changes and Timing of Substitutions (§§ 423.4, 423.100, and 423.120(e)(2))

Background: Biosimilars are intended to bring about low-cost competitors to biologic products, accruing savings through lower prices. Currently, Part D plans are not allowed to substitute biosimilars for their biologic reference products during the plan year on the formulary without explicit CMS approval unless the biosimilar is designated as interchangeable. To be deemed interchangeable, a biosimilar is subject to additional FDA requirements, and many approved biosimilars are currently not designated as interchangeable. However, FDA review ensures that all approved biosimilar biological products are as safe and effective as their biologic reference products and meet the FDA's high standards for approval and manufacturing.

Policy Position: We support the CMS proposal to include substitutions of biosimilar biological products other than interchangeable biological products for their reference products as maintenance changes.

Justification: This change would make the process for substituting biosimilars for their reference biologics more streamlined for Part D plans and would promote greater access to biosimilar products amongst patients. We believe that it is important to have policies such as these in place to strengthen biosimilar competition that would bring savings and lower premiums for families, patients, and taxpayers.

III. J. Standardize the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Appeals Process (§ 422.311)

Background: MS proposes to streamline the RADV medical record review determination and payment error calculation appeals process including through proposed changes that would: 1) prevent Medicare Advantage Organizations (MAOs) from appealing medical record review determinations and payment error calculation at the same time, and 2) require MAOs to exhaust all levels of appeal for medical record review determinations before appealing the payment error calculation.

Policy Position: We support CMS' proposal to streamline the RADV appeals process and think that the proposed changes are reasonable steps to improve the consistency and efficiency of appeal adjudications. Ultimately, however, we believe larger reforms are needed to make the RADV process effective at recouping overpayments. Given the substantial evidence of overpayments to MA plans, CMS should also contemplate broader reforms to reduce overpayments to MA plans, in addition to improving the process for recouping improper payments. This can include increasing the coding intensity factor to fully account for plan upcoding of beneficiary diagnoses and building on reforms to the risk adjustment system that can curb plan upcoding and ensure more appropriate MA payments.

Justification: The evidence shows that MA plans are paid more than traditional Medicare for similar enrollees. In 2023, the Medicare program is projected to overpay MA plans by about \$27 billion annually¹. A major driver of these overpayments is the prevalence of upcoding, where MA plans intensively code beneficiary diagnoses to make them appear less healthy and to increase plan payments.² The RADV audit process plays a role in identifying and recouping overpayments that

¹ Medicare Payment Advisory Commission. [The Medicare Advantage Program: Status Report](#). January 2023

² Medicare Payment Advisory Commission. [Chapter 11: The Medicare Advantage Program: Status Report](#). March 2023.



result from MA plans documenting diagnosis codes that are not supported by the medical record, improperly inflating their payments. Given the limited resources CMS has to conduct RADV audits and appeals, the proposed changes are reasonable steps to improve the efficiency of the RADV appeals process. Since the payment error calculation is dependent on the medical review record determination, the proposed changes can reduce unnecessary or moot appeals and create more consistent appeals decisions by eliminating the ability to simultaneously move appeals requests related to both the medical record review determinations and payment error calculations.

However, major challenges still exist that limit the effectiveness of the RADV process at recouping overpayments and deterring MA plans from submitting unsupported diagnoses. For example, while CMS has made improvements in targeting audits to the highest risk MA plans, only a small share of contracts is audited annually. In addition, there are substantial delays in the audits and appeals process that limit CMS's ability to recover improper payments. Beyond the proposed changes, CMS could also improve the effectiveness of RADV audits by auditing a larger share of plan contracts, imposing penalties on plans for improper diagnosis coding that exceed the amount of the overpayment, and limiting the time period to resolve RADV appeals. These changes could help CMS recover a larger amount of the improper MA payments made each year.

Ultimately, reforms beyond changes to the RADV process are needed to address overpayments. A substantial share of overpayments to MA plans reflects aggressive but valid diagnosis coding that is not addressed by RADV audits, and the RADV process is not well positioned to be able to keep pace with MA plans' evolving coding practices. CMS should take additional steps to directly address overpayments that stem from MA plans' coding efforts. We strongly support increases to the coding intensity factor to fully account for plan upcoding of beneficiary diagnoses, which could be implemented in a way that recognizes variation in coding intensity across MA plans. We also urge CMS to consider additional reforms to the risk adjustment model to reduce the influence of intensive coding on payments, including larger scale reforms such as mitigating the impact of diagnosis codes that are particularly subject to intensive coding and incorporating alternative, non-plan provided sources of data into risk adjustment. We believe that these types of reforms can help CMS more meaningfully reduce MA overpayments.

IV. C. Mid-Year Notice of Unused Supplemental Benefits (§§ 422.111(1) and 422.2267(e)(42))

Background: CMS proposes to address awareness and utilization of supplemental benefits by requiring MA plans to notify enrollees mid-year of their unused supplemental benefits. Beginning January 1, 2026, MAOs must mail a mid-year notice annually to each enrollee outlining the supplemental benefits that are available to them but that they have not yet utilized during that plan year. The notice should include information such as applicable cost sharing and instructions on how to access the benefits.

Policy Position: We appreciate the steps that CMS is taking to increase transparency in the MA program and ensure MA plans are not using supplemental benefits largely as a marketing tool by requiring MA plans to notify enrollees mid-year of their unused supplemental benefits. CMS could further their efforts to improve oversight of the benefits provided by MA plans by collecting more robust information on supplemental benefits (e.g., by requiring complete and accurate encounter data on the cost and utilization of the supplemental benefits offered through MAOs) and making these data available to researchers.

Justification: There is considerable variation in the scope and generosity of supplemental benefits offered by MA plans. The current lack of data about enrollees' use of supplemental benefits



makes it difficult to conduct appropriate oversight of the program and to assess whether the supplemental benefits offered by MAOs improve beneficiary health outcomes and promote health equity. For example, we do not know how the use of supplemental benefits varies by enrollee characteristics and whether the use of supplemental benefits leads to fewer adverse events or better health outcomes.³ These data could also allow researchers and policymakers to assess equity implications since current evidence shows that non-Medicare-covered supplemental benefits appear to be tailored more toward relatively healthy populations instead of populations with the greatest social and medical needs.⁴ Improving the data on supplemental benefits would help generate evidence that can promote greater transparency and a better understanding of the value of supplemental benefits and of the MA program for beneficiaries and taxpayers.

VI. B. Agent Broker Compensation

Background: To ensure that agents and brokers provide beneficiaries with unbiased advice that is not influenced by brokers' financial interests when selecting an insurance option, CMS is proposing to set a single agent/broker compensation rate for all MA plans, revise the scope of items and services included within agent and broker compensation, and eliminate separate payments to agents and brokers for administrative services. In addition, CMS is proposing to prohibit contract terms between MAOs and agents, brokers, or other third-party marketing organizations that may interfere with the agent or broker's ability to objectively assess and recommend the plan that best fits a beneficiary's health needs. CMS also proposes to make conforming edits to the Part D agent/broker compensation rules.

Policy Position: We strongly support CMS' proposed changes to agent/broker compensation and contracting terms and believe they are critical to ensure agent/broker compensation incentives are aligned with the goal of providing accurate, unbiased information to beneficiaries and to promote a competitive MA market. In future rulemaking, we suggest that CMS consider ways to further align agent/broker compensation incentives between MA plans and Part D plans in traditional Medicare and build on recent actions to regulate MA marketing practices by protecting beneficiaries from deceptive tactics that undermine their ability to make informed coverage decisions.

Justification: Selecting an insurance plan can be overwhelming for beneficiaries because of the variety of plans from which they can choose and insufficient information about the plans' networks and providers. Beneficiaries are also subject to aggressive and misleading marketing tactics and steering by brokers toward certain plans based on financial incentives. Broker compensation from enrolling beneficiaries in MA plans has been growing rapidly in recent years, reaching up to \$1,300 per enrollee per year through additional administrative payments, which is more than twice the current compensation limit set by CMS.⁵ Because compensation varies across MA plans, this creates incentives for brokers to steer beneficiaries to plans that pay them more.⁶ The proposed changes in this rule take critical steps to address misaligned financial incentives for agents and brokers that currently contribute to a more consolidated MA market

³ Fuglesten Biniek, J., et al. [Gaps in Medicare Advantage Data Limit Transparency in Plan Performance for Policymakers and Beneficiaries](#). Kaiser Family Foundation. April 2023.

⁴ Medicare Payment Advisory Commission. [Chapter 11: The Medicare Advantage Program: Status Report](#). March 2023.

⁵ Alliance of Community Health Plans. [MA for Tomorrow: Improving Consumer Navigation](#). December 2023.

⁶ Ali, R. and Hellow, L. [Agent Commissions in Medicare and the Impact on Beneficiary Choice](#). The Commonwealth Fund. October 2021.



and to agents and brokers steering beneficiaries to certain health MA plans based on compensation rather than providing unbiased guidance that helps them select a plan that best fits their needs. While these changes are essential to level the playing field and improve competition in the MA market, agents and brokers are still likely to face higher compensation for enrolling beneficiaries in an MA plan compared to their compensation for enrolling beneficiaries in a Part D plan even when combined with a Medigap plan, which could affect their ability to provide unconflicted advice. In future rulemaking, CMS could consider further addressing the differences in compensation rates between MA plans and Part D plans so that agents and brokers are not financially motivated to enroll beneficiaries in MA plans over traditional Medicare with Part D plans.

Beyond addressing the misaligned financial incentives facing agents and brokers, CMS could also consider additional reforms to address deceptive marketing that may limit beneficiaries' ability to make an informed decision about the health insurance option that works best for them. We believe CMS should continue to build upon regulations around MA marketing in the CY 2023 and CY 2024 Final Rules to protect beneficiaries from unsolicited contact from agents/brokers and misleading tactics.^{7,8} Specifically, we suggest that CMS: (1) further limit the use of the Medicare name in private hotlines or non-government websites, which can confuse beneficiaries looking for 1-800-Medicare or Medicare.gov and represents a grey area in the CY 2024 Final Rule requirement prohibiting any misleading use of the Medicare name;⁹ (2) require marketers to disclose that MA plans have limited provider networks with fewer physicians and hospitals than traditional Medicare and that beneficiaries pay more if they go out-of-network for covered services; and (3) expand the "effect on current coverage" section in the Pre-Enrollment Checklist so that beneficiaries are informed that they could be denied a Medigap policy should they switch to traditional Medicare after remaining in MA for more than one year. We also believe CMS should provide support for sources of accurate and unbiased information outside of commercial interests to meet beneficiary demands for assistance with choosing plans, like State Health Insurance Assistance Programs and the Senior Medicare Patrol, as recommended by the Senate Finance Committee.¹⁰

VIII. C. 1. Changes to the Special Enrollment Periods for Dually Eligible Individuals and Other LIS Eligible Individuals (§ 423.38(c)(4)(i))

Background: Today, outside of open enrollment, people who are dual-eligible can take advantage of a special enrollment period (SEP) on a quarterly basis and pick any coverage option for which they are eligible. Beginning in 2025, CMS proposes to remove this quarterly SEP and add two new once-per-month SEPs: (1) that would allow dual-eligible individuals and those with a low-income

⁷ Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Federal Register Volume 87. [Rule Number 89](#). Page Number 27704. May 2022.

⁸ Medicare Program; Contract Year 2024 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. Federal Register Volume 88. [Rule Number 70](#). Page Number 22120. April 2023.

⁹ Medicare Program; Contract Year 2024 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. Federal Register Volume 88. [Rule Number 70](#). Page Number 22120. April 2023.

¹⁰ U.S. Senate Committee on Finance. [Deceptive Marketing Practices Flourish in Medicare Advantage: A Report by the Majority Staff of the U.S. Senate Committee on Finance](#). November 2022.



subsidy (LIS) to choose traditional Medicare coverage and a standalone Prescription Drug Plan (PDP) (which could entail switching PDPs or leaving their Medicare Advantage Prescription Drug Plan (MA-PD) for traditional Medicare plus a standalone PDP), and (2) that would allow dual-eligible individuals to select an integrated D-SNP, including a FIDE-SNP or a HIDE-SNP. In effect, these proposals would limit the ability of a dual-eligible individual to enroll in a non-integrated MA plan outside of the open enrollment period, which is in parity with people who are not dual-eligible. CMS is also considering modifying the Medicare enrollment effective date associated with the integrated SEP to allow states to align it with their Medicaid enrollment effective dates.

Policy Position: We support CMS' recommendation to revise the SEP for the dual-eligible population and those with a low-income subsidy to once-per-month into traditional Medicare and a stand-alone PDP or an integrated D-SNP. We also encourage CMS to modify the Medicare SEP enrollment effective date to allow alignment with Medicaid enrollment effective dates.

Justification: The new SEP process that CMS proposes provides people who are dual-eligible with additional flexibility, while simultaneously promoting D-SNPs that integrate Medicare and Medicaid. We believe this creates a more meaningful choice landscape for people who are dual-eligible.

We believe that it is appropriate to allow people who are dual-eligible to use their new monthly SEP to switch plans to enroll into an integrated D-SNP because these models show promise in improving outcomes. Integrated models, like integrated D-SNPs, have been associated with decreased use of nursing homes and increased use of care in the home or community, which is the preferred care setting for most Americans.^{11, 12, 13} Limited analyses also point to evidence of increased care coordination, such as more frequent instances of post-hospitalization follow-up care,¹⁴ as well as self-reported improvements in patient experience and quality of life.¹⁵ Integrated D-SNPs can also reduce administrative burden for the dual-eligible population—for example, integrated D-SNPs can offer one insurance card instead of two, one prior authorization process for people and their providers to navigate, and one call line that can support people and their providers with any questions they may have about their coverage.

Additionally, providing states with the flexibility to align the new SEP enrollment period with the Medicaid enrollment period allows people who are dual-eligible to make a holistic decision about their coverage, inclusive of both Medicare and Medicaid coverage options, and can facilitate enrollment in integrated models.

We also believe that it is appropriate to limit mid-year enrollment into MA plans that are not integrated. We don't believe the selection of an alternate non-integrated MA plan during the plan year reflects a meaningful plan selection, but instead reflects aggressive marketing tactics that MA plans that are not integrated can use to encourage people who are dual-eligible to enroll in their plans. While this is a problem for all Medicare beneficiaries, people who are dual-eligible can be

¹¹ US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. [Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report](#). September 2021.

¹² Medicaid and CHIP Payment and Access Commission. [Evaluations of Integrated Care Models for Dually Eligible Beneficiaries Key Findings and Research Gaps](#). August 2020.

¹³ Center for Medicare and Medicaid Services. [Financial Alignment Initiative MyCare Ohio: Third Evaluation Report](#). October 2023.

¹⁴ Center for Medicare and Medicaid Services. [Financial Alignment Initiative MyCare Ohio: Third Evaluation Report](#). October 2023.

¹⁵ Center for Medicare and Medicaid Services. [Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative](#). March 2017.



disproportionately targeted. This is because under current regulations, people who are dual-eligible may change coverage on a quarterly basis, resulting in targeting throughout the year, rather than just during open enrollment. The volume of marketing materials beneficiaries receive can be incredibly overwhelming.¹⁶ By excluding general MA plans from the new monthly SEP, these aggressive marketing tactics and associated confusion may be mitigated.

While we support this provision and believe this SEP change will result in more meaningful choices for people who are dual-eligible, should the provision be finalized, we encourage the Secretary to ensure careful and comprehensive beneficiary communications. As proposed, people who are dual-eligible would have one set of coverage options available during the open enrollment period and a different set for the SEP—this has the potential to create confusion for beneficiaries, their caregivers, and those who provide plan options counseling. As part of CMS' implementation of these changes, we encourage the agency to develop a strategic communications plan on how best to communicate this SEP with people who are dual-eligible. This should include how this information is displayed on Plan Finder outside of the open enrollment period, how it is relayed through call centers, and a plan to leverage trusted sources of information for people who are dual-eligible to ensure that they understand their available coverage options as it applies to the SEP.

VIII. C. 2. Enrollment Limitations for Non-Integrated Medicare Advantage Plans – Aligning Service Areas and Limiting Plans

Background: CMS proposes to require that MAOs, their parent organizations, or entities that share a parent organization with the MAO that operate a D-SNP and are contracted with a state as a Medicaid managed care organization (MCO) to serve full-benefit dual-eligible individuals only be permitted to operate a single D-SNP in the same service area as the organization's Medicaid MCO. CMS proposes to allow exceptions if a state opts to require MAOs to operate more than one D-SNP as part of its integrated care program design (e.g., the state requires the organization to operate distinct D-SNPs based on dual-eligible individual age). CMS does not propose to extend these limitations to D-SNPs that do not operate a Medicaid MCO.

Policy Position: We are supportive of CMS' proposal to limit MAOs to one D-SNP offering per service area where the MAO operates a Medicaid MCO. We also support an exception process for states as outlined in the proposed rule. In addition, we strongly encourage CMS to consider limiting its contacts with non-integrated D-SNPs where integrated D-SNPs exist or at minimum, extend the proposed limitations to non-integrated D-SNPs.

Justification: Ninety-six percent of Medicare beneficiaries said they have what feels like too many plan options.¹⁷ Dual-eligible beneficiaries may be faced with over 100 different coverage offerings.¹⁸ CMS explains in the proposed rule that in some markets, a handful of carriers are offering multiple D-SNPs in a market—for example, UnitedHealth Group specifically operates 15 different D-SNPs across 6 different contracts in a particular market.¹⁹ An overwhelming choice set

¹⁶ Freed, M., et al. [What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?](#) Kaiser Family Foundation. September 2023.

¹⁷ Jacobson, G., et al. [Private Plan Pitch: Seniors' Experiences Medicare Marketing](#). The Commonwealth Fund. September 2023.

¹⁸ Rizer, A. [Is Too Much Choice a Bad Thing?](#). Anne Tumlinson Innovations Advisory. July 2021.

¹⁹ Medicare Program; Contract Year 2025 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; Health Information Technology Standards and Implementation Specifications. Federal Register Volume 88. [Rule Number 219](#). Page Number 78571. November 2023.



reduces anyone's ability to make a decision²⁰ and the current set of plan offerings fails to promote enrollment among people who are dual-eligible into plans that offer their full range of benefits. Limiting MAOs to one D-SNP per overlapping MCO service area will reduce the number of plans available and thus confusion. In certain cases, however, it may be appropriate to offer more than one D-SNP given the design of the state's efforts to integrate its Medicaid program with Medicare. For example, states sometimes limit enrollment in certain D-SNPs based on age group or allow parent organizations to operate both HMO and PPO D-SNPs. These examples reflect instances where multiple D-SNPs are additive rather than redundant, making them worthwhile exceptions, so long as the state sees them as such. Thus, we are supportive of CMS' proposal to permit an exception process to this policy which would be led by states.

At the same time, we are concerned that D-SNPs that do not have a Medicaid MCO contract will be permitted to continue to operate where integrated D-SNPs are available. We believe this is a significant gap in CMS' proposal that could undermine its efforts to reduce confusion and increase enrollment in integrated D-SNPs. D-SNPs offer people who are dual-eligible value because they are tailored to their needs and can integrate with their Medicaid coverage, which as previously stated, the evidence shows can have benefits for people who are dual-eligible. If they are not integrated, D-SNPs represent another choice in an already crowded landscape of coverage options, many of which are not meaningful as CMS outlines throughout this proposed rule. Ideally, CMS no longer signs contracts for non-integrated D-SNPs. where an integrated D-SNP is available in its description of these proposed changes, CMS states, "we have the authority per section 1857(e)(1) of the Act, to add MA contract terms and conditions... the Secretary may find necessary and appropriate... Further, section 1857(e)(1) of the Act is clear that we are not obligated to accept any and every MA plan bid." At a minimum, we encourage CMS to apply the limitations on the number of D-SNPs each entity can offer to non-integrated D-SNPs as well, creating parity amongst integrated and unintegrated D-SNPs.

VIII.C.2. Enrollment Limitations for Non-Integrated Medicare Advantage Plans – Exclusively Aligned Enrollment

Background: CMS proposes to limit enrollment into D-SNPs in instances when the D-SNP's Medicare Advantage Parent Organization or entity within that organization also contracts with a state as a Medicaid MCO enrolling dual-eligible individuals in the same service area. This policy would be phased in over time to reduce confusion. Beginning in 2027, people who are dual-eligible and newly enrolling into an integrated D-SNP will only have the integrated D-SNP aligned with their Medicaid coverage option available to them. Then in 2030, people who are dual-eligible enrolled in an integrated D-SNP will only be able to stay enrolled in their integrated D-SNP if they are in the same D-SNP and Medicaid MCO. These efforts to align D-SNP enrollment with Medicaid MCO enrollment – sometimes referred to as exclusively aligned enrollment – would only apply to integrated D-SNPs. D-SNPs operating in a state that does not have a Medicaid MCO contract would be permitted to continue to enroll people who are dual-eligible, even when the person who is dual-eligible is enrolled in a Medicaid MCO operated by a different organization.

Policy Position: We strongly support CMS' proposal to align enrollment between integrated D-SNPs and Medicaid MCOs. However, we encourage CMS to implement a limited exception process for states that allow carve-outs and Medicaid fee-for-service to compete alongside Medicaid MCOs.

Justification: As previously outlined, models that integrate Medicare and Medicaid coverage, like

²⁰ Iyengar, S., et al. [When Choice is Demotivating: Can One Desire Too Much of a Good Thing?](#). December 2000.



integrated D-SNPs, can have a positive impact on beneficiary outcomes and experience. However, coverage cannot be integrated unless a person is enrolled in the same organization for their Medicare and Medicaid coverage. Even where integrated D-SNPs operate today, enrollment in these plans is often treated separately from enrollment in a Medicaid MCO. This means that even though these plans are called integrated, they are only integrated if the person picks the same entity for their D-SNP and Medicaid MCO coverage. This is confusing to people trying to enroll in coverage and those who support people in understanding their coverage options. As a result of this policy, even though there are five million people now enrolled in a D-SNP, just over one million are enrolled in an integrated coverage option operated by the same entity.²¹ If finalized as proposed, CMS' proposal would greatly improve the choice landscape by effectively saying that an integrated D-SNP and its companion Medicaid MCO are one coverage option, rather than two.

While we support the proposal, we believe that a very limited exception process is appropriate to account for state program design. For example, it is our understanding that at least one state permits Medicaid fee-for-service to compete with Medicaid managed care organizations for enrollment. In this instance, it may be appropriate to permit someone enrolled in Medicaid fee-for-service to enroll in a D-SNP that operates a Medicaid MCO. This logic could also be extended to people who are dual-eligible that are not permitted to enroll in Medicaid managed care today because the population is carved out from Medicaid managed care. We believe these exceptions should be limited, and initiated by the states, not the entities operating D-SNPs.

Additionally, this policy to align Medicare and Medicaid enrollment would only apply to integrated D-SNPs. To realize the full potential of integrated options, CMS should also take steps to reduce the availability of non-integrated D-SNPs. As previously suggested, we strongly believe that where integrated D-SNPs are available, non-integrated D-SNPs should no longer be permitted to operate or should at a minimum be required to comply with the same requirements as integrated D-SNPs. In the instance of aligned enrollment, this could mean that a non-integrated D-SNP could only enroll people who are not enrolled in a Medicaid MCO.

VIII. G. 1. Reducing Threshold for Contract Limitation on D-SNP Look-Alikes (§ 422.514)

Background: Today, many non-SNP MA plans target and enroll significant numbers of dual-eligible individuals, thereby detracting from enrollment among this population in options that coordinate with their Medicaid benefits. In the June 2020 CMS final rule, CMS introduced contract limits on non-SNP MA plans with 80% or more dual-eligible enrollment, deemed D-SNP “look-alike” plans. In subsequent final rules, CMS has increased the limitations on look-alike plans. In the past few years, the number of non-SNP plans with dual-eligible enrollment between 50% and 80% has continued to grow, as has the number of dual-eligible individuals enrolled in these plans.²² In this rule, CMS proposes to decrease the threshold at which a non-SNP is considered a look-alike plan from 80% dual-eligible enrollment to 70% in 2025 and 60% from 2026 onwards.

Policy Position: We support CMS' proposal to decrease the D-SNP look-alike threshold for non-SNP plans and encourage CMS to reduce the threshold to 50%. We also recommend that CMS

²¹ Medicare Program; Contract Year 2025 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; Health Information Technology Standards and Implementation Specifications. Federal Register Volume 88. [Rule Number 219](#). Page Number 78571. November 2023.

²² Medicare Program; Contract Year 2025 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; Health Information Technology Standards and Implementation Specifications. Federal Register Volume 88. [Rule Number 219](#). Page Number 78580. November 2023.



require Medicare to inform beneficiaries when they are enrolling in a non-integrated model where an integrated model exists.

Justification: The targeting of dual-eligible individuals by non-SNP plans often prevents this group from enrolling in models that integrate their Medicare and Medicaid benefits. This concern applies not only to plans with over 80% dual-eligible enrollment. As CMS notes, today, in at least 128 non-SNP plans, dual-eligible individuals make up between 50-80% of the total plan enrollment, and enrollment in these plans is growing. Enrollment levels this high suggest active targeting of the dual-eligible population. We recognize that there are several service areas where dual-eligible individuals make up approximately 50% of the total Medicare population. While penetration rates are a noteworthy consideration in designing the look-alike policy, we maintain that any plan where more than 50% of the membership is comprised of people who are dual-eligible should be subject to the same additional requirements and oversight as D-SNPs to protect the people enrolled in these plans. One additional opportunity to limit the reach of look-alikes and other non-SNP plans with high levels of dual-eligible enrollment is to require Medicare to inform beneficiaries when they are enrolling in a non-integrated model where an integrated model exists. These disclosures would shift the education burden from the individual, where it sits today, to the entities providing the coverage.

VIII. I. Expanding Permissible Data Use and Data Disclosure for MA Encounter Data (§ 422.310)

Background: Today, states are able to request Medicare and MA encounter data for their dual-eligible population. CMS proposes to clarify and expand states' permissible access and use of the data. More specifically, states would be able to use MA encounter data to support their Medicaid programs specifically, which was not clear previously. Furthermore, CMS would grant states access to encounter data sooner, before the MA plans' risk adjustment data goes through the reconciliation process for the purpose of coordinating care for people who are dual-eligible.

Policy Position: We support expanding states' access to and early use of MA encounter data to better coordinate care services for the dual-eligible population.

Justification: Current regulatory language under § 422.310(f) may discourage state Medicaid programs from accessing MA encounter data.²³ These data sets can provide states with critical information that can support integrating their Medicaid coverage with Medicare coverage for the growing number of dual-eligible individuals enrolling in MA products.²⁴ CMS has reported a four-fold increase in the number of dual-eligible individuals enrolled in MA with 12% enrolled in 2006 compared to 51% in 2021.²⁵ By promoting access to MA encounter data, states will have the ability to identify a considerable portion of their dual-eligible population who are Medicaid-eligible, coordinate their care, and monitor their service utilization and outcomes. Furthermore, access to these data can empower Medicaid programs to incorporate dual-eligible individuals' utilization data into the creation of more tailored integrated care programs that best serve the needs of their dual-eligible populations. Providing states with access to these data sooner than ever before also only

²³ Medicare Program; Contract Year 2025 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; Health Information Technology Standards and Implementation Specifications. Federal Register Volume 88. [Rule Number 219](#). Page Number 78526. November 2023.

²⁴ Brown-Podgorski, B. & Roberts, E. [Integrating Medicare and Medicaid Data to Improve Care Quality and Advance Health Equity Among Dual-Eligible Beneficiaries](#). Health Affairs. November 2022.

²⁵ Center for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office. [Data Analysis Brief: Comparing Managed Care Enrollment Trends Among Dually Eligible Individuals to Medicare-only Beneficiaries, 2012 Through 2021](#). October 2022.



serves to support these ends.

VIII. H. For D-SNP PPOs, Limit Out-of-Network Cost Sharing (§ 422.100)

Background: Today, out-of-network cost-sharing within preferred provider organization (PPO) D-SNPs often significantly exceeds cost-sharing within fee-for-service Medicare for the same services. As a result, certain people who are dual-eligible who still have some responsibilities for cost-sharing and receive care from non-network providers may owe exorbitant bills. For other people who are dual-eligible, these high costs can either fall on to the state to pay or represent bad debt to the providers, discouraging providers from wanting to care for people who are dual-eligible. To address this concern, CMS proposes to limit out-of-network cost sharing for professional services and other specific benefits in PPO D-SNPs, including primary care services, physician specialist services, partial hospitalization, rehabilitation services, chemotherapy, renal dialysis, skilled nursing care, home health services, durable medical equipment, and Part B drugs. Cost sharing for these out-of-network services and benefits would be capped at the rates that currently apply to in-network benefits. In most cases, the rates would be required to match the cost-sharing rates under Traditional Medicare.

Policy Position: We are supportive of CMS' proposal to limit D-SNP PPO cost-sharing.

Justification: The current policy can lead to high levels of cost-sharing for certain dual-eligible individuals, potentially prohibiting their use of necessary out-of-network providers. In states that use Medicaid rates to cover Medicare cost-sharing for dual-eligible beneficiaries, providers may receive a lower reimbursement rate than they would through fee-for-service Medicare, potentially disincentivizing providers from serving dual-eligible beneficiaries. State Medicaid Agencies that pay the full Medicare cost-sharing amounts for all Medicare services also currently face prohibitive costs. Ultimately, the current policy undermines the purpose of PPOs in extending provider networks. The proposed amendment would resolve these issues, allowing dual-eligible individuals to reap the intended benefits of this plan type.

VIII. D. Comment Solicitation: Medicare Plan Finder and Information on Certain Integrated D-SNPs

Background: CMS requests feedback on improvements to the Medicare Plan Finder to support dual-eligible individuals' plan shopping experience, including whether Medicaid benefits should be listed on the website.

Policy Position: We support CMS' intention to improve the Medicare Plan Finder to support dual-eligible beneficiaries. We recommend that Medicare Plan Finders' default display list integrated D-SNPs first for people who are dual-eligible. We additionally recommend that Medicare Plan Finder display a more complete picture of the benefits available through D-SNPs, including the supplemental Medicaid benefits that the beneficiary would receive if enrolled in an affiliated Medicaid managed care organization contract. We additionally recommend the following changes to Plan Finder:

- On the "Help with your costs" page, allow users to select multiple options, including Medicaid and the Medicare Savings program.
- Make it clear to users that when they filter to view "Plans for people who have both Medicare and Medicaid," they can see all available MA plans, in addition to D-SNPs—currently all other filters on the website remove plan options; it is confusing that this filter is the only one that adds options.
- If a user selects that they receive help with costs from another program (e.g., the Medicare Savings Program), the costs shown on the plan results page should reflect this help.



Currently, if a user selects that they are enrolled in the Medicare Savings Program, for example, Plan Finder shows Part B premiums on the results page, which a beneficiary is not responsible for.

Justification: Medicare Plan Finder is a crucial resource for beneficiaries navigating their insurance options and for caregivers, SHIP counselors, and others who support beneficiaries in their decision-making. Unfortunately, this resource does not always provide dual-eligible individuals and their caregivers with the information they need to enroll in a plan that best meets their needs. Rectifying Plan Finders' shortcomings for the dual-eligible population requires elevating the availability of integrated and aligned options and ensuring that web users can appropriately weigh the benefits of these options relative to non-integrated or non-aligned options. Restructuring Plan Finder to filter D-SNPs to the top of the list for eligible beneficiaries helps ensure that dual-eligible individuals are aware of this option, thereby facilitating enrollment, as appropriate. Similarly, by including not only the MA supplemental benefits associated with an integrated option, but the Medicaid supplemental benefits associated with the affiliated plan, dual-eligible beneficiaries can understand a fuller picture of what they would receive. The bulleted recommendations included above reflect areas of confusion for dual-eligible individuals on the current website that could be corrected through the suggested minor updates.

We, alongside our partners, submitted a letter to CMS earlier this year that outlines these recommendations as well.²⁶

Conclusion

Arnold Ventures is prepared to assist with any additional information needed. Please contact Arielle Mir at amir@arnoldventures.org, Erica Socker at esocker@arnoldventures.org, or Andrea Noda at anoda@arnoldventures.org. Thank you again for the opportunity to comment and your consideration of the above.

Mark Miller

²⁶ Abdnor, A. [Dual Eligible Americans Need Support During Medicare Open Enrollment](#). Arnold Ventures. October 2023.