National
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Health Plan Association

January 21, 2025

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10796, OMB control number: 0938-1410
Room C4-26-05
7500 Security Boulevard, Baltimore, Maryland 21244-1850

Dear CMS Administrator,

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on the revisions to the Dual Eligible Special Needs Plan (D-SNP) Contract with the State Medicaid Agency (SMAC) Application.

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid[1]. Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Our members also offer integrated care options, including Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs). We cover the majority of enrollees in MLTSS plans and integrated plans, including national plans and regional and community-based plans.

Advancing integrated care for dually eligible beneficiaries has been a top priority for the MLTSS Association since its inception. We greatly appreciate CMS' commitment and continued focus on improving our integrated care delivery system, while keeping the beneficiary experience at the center of your efforts. We appreciate the opportunity to collaborate with CMS on this comment opportunity as CMS continues to refine the SMAC application for D-SNPs.

Proposed Attestation: For organizations seeking HIDE, FIDE, or AIP status, upload the effectuated Medicaid Managed Care contract with the affiliated Medicaid managed care organization and the state, including the service area covered by the Medicaid managed care contract.

[1] Members include Aetna, AlohaCare, AmeriHealth Caritas, CareSource, Centene, Commonwealth Care Alliance, Elevance Health, Florida Community Care, Humana, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, United Healthcare, UPMC Community Health Choices

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CMS' rationale for including this new attestation is to ensure that D-SNPs applying for HIDE, FIDE, or AIP status are compliant with the May 2022 Medicare Advantage and Part D Final Rule, which requires that each HIDE and FIDE SNP's capitated contract with the state Medicaid agency apply to the entire service area for the D–SNP for plan year 2025 and subsequent years. CMS estimates that the additional burden on D-SNPs to complete this attestation will be approximately 15 minutes per contract, inclusive of time to identify and upload the correct documentation.

The MLTSS Association supports CMS' proposed update to the SMAC attestation. We believe this update will ensure greater transparency and compliance with new policies aimed at increasing the number of integrated plan offerings for dual eligible beneficiaries.

Additional Recommendations

The MLTSS Association sees an opportunity to support states, plans, and CMS by making targeted enhancements to the SMAC Application to capture important D-SNP administrative details. Currently, SMACs vary significantly in their level of regulatory and operational details and some key elements such as integration level, cost-sharing requirements, benefits, and material review scope and timing are sometimes not determined in sufficient time to support successful implementation.

Building on the existing framework, we recommend the following additions to the SMAC Application to allow for greater specificity at the Plan Benefit Package (PBP) level so that states can have greater oversight, plans are able to operationalize requirements, and most importantly, beneficiaries can benefit from enhanced integration and a more seamless experience as intended by CMS.

Basic D-SNP SMAC Requirements Matrix

We recommend adding the following level of detail so that CMS, states and plans can better identify specific plan offerings under these SMAC contracts. This will enable SMACs to serve as a source of truth document for all plan offerings. We recommend requiring language regarding plan specific details including, but not limited to the H contract code, plan name, PBP number, integration status, bid filing, MSP categories that are eligible to enroll in the PBP, and the counties served within that PBP. We see this as an addendum to the contract, with a chart or language including those details.

Example D-SNP SMAC Requirements Matrix:

CMS H Contract Code	Plan Name	Plan Benefit Package	Integration Status	Zero or Non-Zero Filed Plan	MSP Eligibles	Counties Served

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Cost Sharing Requirements

We recommend that CMS include a new requirement in the SMAC Application for plans to submit a cost share chart that details the cost sharing responsibilities for different MSP eligibility categories. Additionally, we recommend that this chart require the following information:

- How the state cost share protects Specified Low-Income Medicare Beneficiary Plus (SLMB+) and full benefit dually eligible (FBDE) members
- The eligibility categories recognized in a state
- If partial eligibility is allowed in a state – if it is not, the partial MSP categories should be removed from the chart below
- The capitated Medicaid benefits, the Medicaid service area, and if the state requires members to pay Part A/B Medicaid copays

Example Cost Share Chart:

Category	Medicare Part A Premiums	Medicare Part B Premiums	Part A Medicare Cost Sharing	Part B Medicare Cost Sharing	Other Medicaid Benefits
QMB only	X	X	X	X	
QMB+	X	X	X	X	X
FBDE	X	X	TBD by State	TBD by State	X
SLMB		X			
SLMB+		X	TBD by State	TBD by State	X
QI		X			
QDQI	X				

We also recommend that the SMAC Application be updated to include language that captures when states will provide health plans with a crosswalk that links the Medicaid category codes to each MSP eligibility category (see the Appendix for an example crosswalk from Pennsylvania).

Medicaid eligibility requirements that require additional PBPs

Currently, the SMAC Application requires plans to provide language regarding age restrictions on enrollment, if applicable (ex: if enrollment in a PBP is limited to individuals who are over age 21, under age 65, or over age 65). The MLTSS Association recommends expanding this requirement to include any eligibility requirements that require separate PBPs. Some states have eligibility requirements for D-SNPs that are based on characteristics beyond age, including whether the member has long-term care needs, and this information is not currently being fully captured on the SMAC Application.

State Material Review

The current SMAC Application does not ask questions about state requirements for review of member materials. However, for many states, this review process is an integral part of creating and/or

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maintaining a D-SNP. The MLTSS Association recommends adding questions to the SMAC Application for Applicable Integrated Plans (AIPs) about which materials the state will review, if any; the timeline for the state's review; material filing (if approval is required or if plans can submit as "file and use"); and language indicating recourse if approval is not received with sufficient time to meet CMS deadlines for beneficiary materials. Further, we recommend options to streamline review of member materials, including potential pathways to expedite review if approval is not received in time to meet Federal Medicare Advantage requirements.

The MLTSS Association appreciates this opportunity to provide feedback on the proposed changes and potential enhancements to the SMAC Application and looks forward to continued partnership with CMS on our shared goal of advancing integrated care. If you have any questions about our response, please feel free to contact Mary Kaschak at mkaschak@mltss.org.

Sincerely,

Mary Kaschak
Chief Executive Officer
MLTSS Association

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Appendix

PA Dual Eligible Quick Reference Guide

To be dual eligible, an individual must be enrolled in Medicare Part A and/or Part B and in Medicaid (full benefits) and/or a Medicare Savings Program (MSP). The chart below identifies the type of dual program for an individual based on their Medicaid program.

Dual Group	Type of Dual	Medicaid Benefits	Medicaid Category Code	Program Status Code (PSC)
Full Dual	**Qualified Medicare Beneficiary Plus (QMB+)**	Full Medicaid health coverage* Payment of Medicare A and B premiums Cost-sharing of expenses incurred under Medicare (i.e., deductibles, coinsurance, and copayments)	A, J, M	All PSC
			PA, PJ, PM	81, 84, 85
			PAN, PJN, PMN, PVN	80
			PAW, PJW, PMW	80, 81, 84, 85
			PH, PI, PW	80
			SBP	80
			TA, TJ	80
Full Dual	**Specified Low-Income Medicare Beneficiary Plus (SLMB+)**	Full Medicaid health coverage* Payment of Medicare B premium Cost-sharing of expenses incurred under Medicare (i.e., deductibles, coinsurance, and copayments)	PAN, PJN, PMN, PVN	66
			PAW, PJW, PMW	66
			PI, PW	66
			TA, TJ	66
Full Dual	**Full-Benefit Medicaid** Individual does not meet the income or resource criteria for QMB+ or SLMB+ but is eligible for Medicaid either categorically or through optional coverage groups based on medical need status, special income levels for institutionalized individuals, or home and community-based waivers.	Full Medicaid health coverage* Cost-sharing of expenses incurred under Medicare (i.e., deductibles, coinsurance, and copayments) See EVS to determine whether Medicare has been added.	C	72
			D	05
			MG	00, 17, 18, 19, 23, 27, 71
			PS	17
			PA, PJ, PM	00, 21, 22
			PAN, PJN, PMN, PVN	00
			PAW, PJW, PMW	00
			PC	30, 31, 32, 33, 34, 35, 36, 37, 40
			PCN	31, 32, 33, 34, 35, 36, 37
			PH	00, 95
			PI, PW	00, 01, 02, 03
			SBP	00
			TA, TC, TJ, TU	00, 22
			TAN, TJN, TVN	00
			U	72

*Medicare providers are not allowed to bill any remaining balance to individuals who have Medicare cost-sharing and full Medicaid health coverage.

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Eligibility	Medicaid Eligibility Category	Benefits	Medicaid Category Code	Program Status Code (PSC)
Partial Dual	**Qualified Medicare Beneficiary (QMB) Only Without Other Medicaid**	No Medicaid health coverage Payment of Medicare A and B premiums Cost-sharing of expenses incurred under Medicare (i.e., deductibles, coinsurance, and copayments) **	PG	00
Partial Dual	**Specified Low-Income Medicare Beneficiary (SLMB) Only Without Other Medicaid**	No Medicaid health coverage Payment of Medicare B premium only	TA, TJ	65
Partial Dual	**Qualifying Individual** (QI)	No Medicaid health coverage Payment of Medicare B premium only	TA, TJ	67
Partial Dual	**Qualified Disabled and Working Individual** (QDWI)	No Medicaid health coverage Payment of Medicare A premium only	PJ, PM	86

**Medicare providers are not allowed to bill any remaining balance to QMB Only recipients due to State payment of coinsurance and deductibles.

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Eligibility	Medicaid Eligibility Category	Benefits	Medicaid Category Code	Program Status Code (PSC)
Non-Dual	**Non-Dual Eligible Beneficiary** Individual has Medicaid but is not enrolled in Medicare or has Medicare but is not enrolled in full Medicaid health coverage or an MSP.	Medicaid health coverage is subject to the recipient's specific category and program status code	MG	38, 39, 90***, 91***
			PC	02, 03, 38, 39
			PCN, PCW	02
			PD, TD	All PSC
			PH	20***, 38, 39
			PJ, PJW	83***
			PSF	14, 15

***Federal requirements stipulate that Medicare recipients cannot be enrolled in or maintain eligibility in the following MA categories: MG90, MG91, PH20, PJ83 or PJW83. Once entitled to Medicare, the individual must be reevaluated for Medicaid as a dual eligible recipient. A recipient in MG90 or MG91 status with Medicare entitlement is not considered dual eligible until their Medicaid status is reevaluated, and they are authorized in a full or partial dual eligible program.