mhpa Medicaid Health Plans of America

January 27, 2025

CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4208-P,
P.O. Box 8013, Baltimore, MD 21244-8013

Re: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CY2026 MAPD Proposed Rule)

Dear CMS Administrator,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on the CY2026 MAPD Proposed Rule.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 160 MCOs serving nearly 48 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries. Below you will find our comments in response to this proposed rule.

Coverage of Anti-Obesity Medications (AOMs) by the Medicaid Program

We appreciate efforts by CMS to expand coverage of AOMs to additional populations, including Medicaid enrollees. We recognize the efficacy of AOMs for treating obesity by facilitating weight loss and chronic weight management, and the innovative nature of these medications. In our comments, we recommend delaying the application of this provision to the Medicaid program and call on CMS to release a separate notice of proposed rulemaking (NPRM) that addresses coverage of AOMs in the Medicaid program. Our specific comments are below.

Recommending a delay in the application of this provision to the Medicaid program
We recommend that CMS delay the requirement that the Medicaid program cover AOMs until the first rating period after January 1, 2027. CMS could accomplish this by delaying the applicability date for the reinterpretation of section 1927(d)(2) of the Social Security Act to that date. We have significant concerns that the current applicability date of 60 days after the final rule is published, which would likely occur in April or May of 2025, would have profound effects on state budgets, prospectively negotiated capitation rates between State Medicaid Agencies and Medicaid Managed Care Organizations (MCOs), and would likely result in a logistically challenging implementation.

CMS notes in their financial impact analysis of the coverage of AOMs in the Medicare program that the proposal would result in $24.8 billion in costs over a ten-year period. CMS did not provide a financial

impact analysis of this proposal's applicability to the Medicaid program, which we believe is problematic, given that one month of coverage of AOMs typically costs ~$1000 per month per individual or more.[1] States are already struggling to pay for high-cost drugs, which account for a major source of spending for state Medicaid programs, with Medicaid spending on prescription drugs increasing from $30 billion in FY2017 to $51 billion in FY2023, a 72% increase.[2] The same analysis by the Kaiser Family Foundation notes that the emergence of high-cost specialty drugs, including new cell and gene therapies, is likely a key driver in these spending increases.[3]

Nationally, Medicaid expenditures account for an average of 12.9% of state budget expenditures according to a 2024 analysis by the Pew Charitable Trusts, and some states, such as Pennsylvania (19.8%), New York (19.4%), and Louisiana (15.8%), spend a much higher share.[4] Requiring coverage of AOMs with such a rapid applicability date does not give states the time needed to plan for such a significant increase in expenditures. We note that as coverage of AOMs is currently optional under the Medicaid program, this applicability date presents challenges for states that are already implementing coverage of these medications on a separate timeline.

One potential solution to gather additional information on the impacts of this change in the Medicaid program would be to implement a voluntary CMMI model which provides a full range of services including AOMs, nutrition support, and exercise. The agency could then evaluate whether the model improved health outcomes and led to cost efficiencies during a longer time frame.

Additionally, while we applaud CMS for their recent actions to enhance access and quality for Medicaid enrollees, and look forward to partnering with states and the Administration to operationalize these changes, the high volume of recent rulemaking will require states to make significant investments in their programs to remain compliant, at the same time as coverage of these drugs is being required. Some of the more significant policy changes include:

- Requiring wait time standards for primary care, OB/GYN, BH, and one state selected service with secret shoppers to verify compliance.
- Requiring managed care plans to submit an annual payment analysis to states.
- State directed payments (SDPs): Average commercial rate provision and requirement that SDPs to be incorporated into Medicaid managed care capitation rates.
- Establishing a Medicaid and CHIP quality rating website and implementation of a mandatory measure set.
- Requiring that states ensure that 80% of Medicaid payments be spent on compensation for direct care workers.
- Requiring minimum nurse staffing levels at long-term care facilities.

Furthermore, capitation rates between State Medicaid Agencies and Medicaid MCOs are typically negotiated on an annual basis, and this applicability date would require states to make retroactive adjustments to rates to account for the new coverage requirements. Should CMS move forward with this rapid applicability date, guidance would be needed to aid states in making these adjustments to rates. We

[1] https://www.healthsystemtracker.org/brief/prices-of-drugs-for-weight-loss-in-the-us-and-peer-nations/
[2] https://www.kff.org/medicaid/issue-brief/recent-trends-in-medicaid-outpatient-prescription-drugs-and-spending/
[3] *Id.*
[4] https://www.pewtrusts.org/en/research-and-analysis/articles/2024/09/12/states-share-of-medicaid-costs-remains-low-but-is-set-to-increase

also recommend that CMS provide guidance on appropriate utilization management measures for anti-obesity medications to assist plans with operationalization of these requirements.

A delay of this provision would allay the concerns raised above, and would allow for implementation of a risk corridor program or other payment adjustment (through a separate NPRM) to account for the unpredictability of the cost of these medications. Indeed, CMS was unable to estimate the financial impact of the required coverage of AOMs in the Medicaid program in this proposed rule.

Calling on CMS to release a separate NPRM that specifically addresses coverage of AOMs in the Medicaid program

In this NPRM, CMS solicits comments on ways to ensure adequate notice to beneficiaries and other stakeholders of the changes resulting from this interpretation, should this proposal be finalized. While we recognize the legal challenges in compartmentalizing the applicability of this reinterpretation to Medicaid in a separate NPRM, we recommend that CMS withdraw this proposal and include it in a separate proposed rule to allow for a robust and transparent exchange with the public. We are concerned that by embedding this proposal in a Medicare-specific NPRM, many key Medicaid stakeholders will not have the opportunity to provide meaningful feedback. This proposal will have a high impact on spending and operations in the Medicaid program, as discussed above, and merits meaningful engagement with the full spectrum of Medicaid stakeholders.

Improving Experiences for Dual Eligible Enrollees

Proposal to require D-SNPs that are Applicable Integrated Plans (AIPs) to have integrated member identification (ID) cards

MHPA supports requiring AIPs to have integrated member ID cards. However, expanding this requirement to all HIDE SNPs (not just AIPs) would cause operational difficulties, as CMS notes, so we do not support expanding this requirement to HIDE SNPs. Without exclusively aligned enrollment, there are two separate entities in play, so although MHPA supports integrated member ID cards in concept, MHPA agrees with CMS' assumption that issuing integrated member ID cards for non-aligned members would be challenging.

Proposal to require D-SNPs that are AIPs to conduct a single integrated Health Risk Assessment (HRA) for Medicare and Medicaid, rather than separate HRAs for each program.

If CMS requires a single integrated HRA for AIPs, CMS should offer technical assistance to states and MCOs to clarify the specifics of an integrated HRA and create a common framework for doing so across all states, since the application of an integrated HRA could otherwise look different in every state, which would be operationally challenging. CMS could consider requiring states with AIPs to integrate CMS HRA components/requirements into their HRAs so that there are common HRA requirements across states. It would also be useful for the Medicaid and Medicare HRA timelines to align to avoid beneficiary confusion and disruption. We further recommend that, in order to ensure that a single assessment does not require beneficiaries to sit for hours responding to questions, the combined HRA/screening that applies across both programs be a base HRA/screening, and that additional questions could be completed separately or as part of a follow-up assessment. Finally, we recommend that the combined comprehensive assessment be required only for the initial screening of enrollee need. This would ensure that states can follow up in the case that more extensive information is needed to assess for long-term services and supports (LTSS) and home and community-based services eligibility screenings, which are limited to applicable enrollees.

Proposal to codify timeframes for Individualized Care Plan (ICP) development

MHPA recommends that CMS provide a timeframe of at least 45 days from the initial HRA for the development and implementation of a comprehensive ICP. Leveraging the enrollment date instead may be challenging. Medicare Advantage plans have 90 days from the date of enrollment to complete the HRA. Therefore, 30 days from the date of enrollment, plans in many cases are still in the process of contacting the member to set up the HRA. At 30 days post-enrollment, if the health plan has not yet successfully contacted the member, the health plan will not know whether the person is going to respond to subsequent attempts to reach them. Creating an ICP 30-days post-enrollment and then subsequently reaching out to create an HRA could trigger the creation of an additional ICP. In addition, at 30 days post-enrollment the plan is not likely to have any claims data yet on which to base the ICP in lieu of the HRA. Further, we ask that CMS consider further increasing the number of days to 60 or 90 days, which both allow for extra flexibility for developing a comprehensive ICP to meet enrollees' needs.

Clarifying Highly Integrated Dual Eligible Special Needs Plan Definition Relative to Oregon's Coordinated Care Organization Structure

We support this proposed change to the HIDE SNP definition, which would explicitly address Oregon's Coordinated Care Organization (CCO) ownership structure. Oregon's CCO model integrates all elements of care, including those required to be deemed a HIDE SNP. Furthermore, the CCO considers the health needs of the community and MA plans involved have financial risk and participate in decision making. The integration status of a D-SNP (FIDE, HIDE, or coordination-only) impacts beneficiary opportunities to enroll in that product. Given that the Oregon CCO meets the high bar of HIDE coordination and integration, dually eligible individuals in Oregon should have full access to this option for founding members by having the model deemed a HIDE SNP.

Once again, thank you for the opportunity to provide comments on the CY2026 MAPD Proposed Rule. Supporting access to care and services for Medicaid beneficiaries is of paramount importance to MHPA. We appreciate the opportunity to share our perspective and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Senior Vice President, Government Relations, Policy, and Advocacy