National
MLTSS
Health Plan Association

January 25, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Dear Administrator Oz:

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on the Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program proposed rule (referred to in this document as "the proposed rule").[1]

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.[2] Our member plans 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. Many MLTSS Association member plans are also leaders in integrated care for dually eligible individuals, offering Dual Eligible Special Needs Plans (D-SNPs) across the full spectrum of integration. In addition, many of our members offer a range of Medicare options, including Chronic Condition Special Needs Plans (C-SNPs) and traditional Medicare Advantage (MA) plans, allowing individuals to choose the plan that best meets their needs.

Advancing integrated care for dually eligible beneficiaries has been a top priority for the MLTSS Association since its inception. Dually eligible beneficiaries make up approximately twenty percent of Medicare and thirteen percent of Medicaid enrollees but account for about one-third of the cost in both programs.[3] Notably, less than ten percent of full-benefit dually eligible beneficiaries are enrolled in programs that

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[1] Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program and Medicare Cost Plan Program. 90 FR 54894. Available at: https://www.federalregister.gov/documents/2025/11/28/2025-21456/medicare-program-contract-year-2027-policy-and-technical-changes-to-the-medicare-advantage-program

[2] Members include Aetna, AlohaCare, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community HealthChoices

[3] 2025 Beneficiaries Dually Eligible for Medicare and Medicaid

integrate Medicare and Medicaid.[4] Given that over 40% of dually eligible beneficiaries use LTSS, the MLTSS Association firmly believes that thoughtfully designed and well-implemented integrated care models have significant potential to improve outcomes and experiences for older adults and individuals with disabilities.[5] In fact, the MLTSS Association has developed a set of policy proposals to advance integrated care.

We appreciate CMS' continued focus on strengthening the MA program and improving integrated care delivery for dually eligible individuals. In the comments that follow, we center the experiences of dually eligible enrollees and the integrated plans that serve them as the primary lens for our recommendations. Broadly, we support CMS' efforts to advance integrated care through aligned enrollment in D-SNPs and to promote high-quality care for all dually eligible individuals enrolled in MA plans. At the same time, we identify key policy and operational considerations that will be critical to the successful implementation of these proposals. Many of the changes contemplated for CY 2027 represent meaningful shifts in enrollment policy, contracting requirements, quality measurement, and plan operations. To be successful, these changes must be implemented on timelines that allow health plans and states sufficient opportunity to understand final requirements, make necessary system and operational adjustments, and comply in a manner that avoids disruption to beneficiary coverage, care coordination, or access to services.

In particular, we underscore the need for additional clarity and guidance regarding 2027 enrollment and operational changes for D-SNPs, especially where differences between the proposed regulatory text and the preamble create uncertainty. Finally, we highlight considerations for CMS as it seeks to refine and improve the MA program more broadly, while avoiding unintended consequences for vulnerable enrollees. We encourage the Agency to carefully assess the potential impact of these changes on D-SNPs' ability to deliver targeted, high-value services to dually eligible individuals and to explore mitigation strategies where appropriate. Furthermore, clear, timely guidance will be essential to ensure consistent implementation and to allow plans to operationalize changes in good faith and in alignment with CMS' goals.

The MLTSS Association offers these comments with the intent of supporting CMS' objectives while highlighting practical considerations that we believe are critical to successful implementation. **We stand ready to serve as a partner to CMS—by sharing operational insights, convening plans, and collaborating on guidance or technical assistance—to help ensure that final policies are both administrable and effective in advancing high-quality, integrated care for dually eligible individuals.**

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)

In the proposed rule, CMS proposes to remove seven Star Ratings measures focused on operational and administrative performance, three measures focused on process of care, and two additional measures

[4] The Landscape of Medicare and Medicaid Coverage Arrangements for Dual-Eligible Individuals Across States | KFF
[5] 2025 Beneficiaries Dually Eligible for Medicare and Medicaid

focused on patient experience of care. CMS also proposes to add the Part C Depression Screening and Follow-Up (DSF) measure to the 2029 Star Ratings (measurement year 2027). CMS plans to begin reporting the DSF measure on the display page for the 2026 Star Ratings. CMS also proposes to not implement the Health Equity Index (HEI) reward (also called the Excellent Health Outcomes for All (EHO4all) reward), opting instead to continue the historical reward factor. Finally, CMS also proposes to codify the current practice of providing sample data for one of each type of measure during the second plan preview.

In addition to feedback on these specific changes, CMS solicits broader feedback on ways to streamline and modify the Star Ratings methodology to further incentivize quality improvement along with suggestions for new outcomes measures to promote prevention and wellness of MA and Part D enrollees to make the Star Ratings program more aligned with Make America Healthy Again (MAHA) efforts related to healthy aging, such as nutrition and patient well-being.

The MLTSS Association appreciates the opportunity to provide input on CMS' proposed updates to the MA and Part D Quality Rating System. We recognize the important role the Star Ratings program plays in shaping plan behavior, driving quality improvement, and informing beneficiary choice, and we value CMS' continued engagement with stakeholders as the agency evaluates opportunities to refine the program over time. While the MLTSS Association does not take a position on these individual proposals, we note that the removal of twelve mostly operational and procedural measures would, as a practical matter, increase the relative weight of remaining measures—particularly outcome and patient experience measures, including those derived from the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey—within the Star Ratings calculation. **This shift heightens the importance of ensuring that patient experience and outcome measures accurately reflect the care experience and health outcomes of all MA enrollees, including dually eligible individuals.**

Dually eligible individuals are a distinct population with complex and intersecting care needs, often including management of multiple chronic conditions, behavioral health needs, LTSS, and social service needs. D-SNPs are also subject to Model of Care (MOC) requirements under which individuals receive individualized care plans and services delivered through interdisciplinary care teams. As a result, dually eligible individuals interact with their health plans in fundamentally different ways than other MA enrollees and often experience different utilization patterns and health outcomes. In this context, quality measures—particularly patient experience measures such as CAHPS—may not fully capture the care experience or quality outcomes of these individuals as they are currently defined.

Both the CAHPS and Health Outcomes Survey (HOS) rely on individuals responding to a survey sent to them in the mail. As a result, responses to these surveys disproportionately reflect individuals that have a stable address to receive mail, the ability to read, comprehend and respond to the survey, and who choose to take the time to respond to an optional healthcare survey administered on behalf of the government. Research suggests that, within the Medicare population, individuals who do not respond to mailed surveys are disproportionately more likely to be age 85 or older, enrolled in Medicaid, or younger beneficiaries with

disabilities.[6] These non-respondents are also more likely to experience poorer health status, higher rates of inpatient utilization, and longer hospital stays. As a result, survey-based measures may underrepresent the experiences of medically and socially complex individuals, including those who are dually eligible. Given these limitations, CMS resources may be more effectively directed toward the development of additional HEDIS measures that provide more timely, objective, and actionable data to support quality improvement efforts.

More broadly, we emphasize that the Star Ratings system is not fully tailored to or responsive to the populations served by D-SNPs. Several studies have identified an association between dual eligibility and lower Star Ratings, with much of this relationship attributed to the higher medical and social complexity of dually eligible individuals rather than differences in care quality.[7] As a result, Star Ratings may not accurately reflect the performance of plans designed specifically to serve dually eligible individuals, and this dynamic risks penalizing plans that serve the most medically and socially complex individuals. **Understanding that D-SNPs serve a meaningfully different population, we encourage CMS to use appropriate discretion in adjusting for the unique factors of this population.**

We also urge CMS to consider the disproportionate impact that Star Ratings changes can have on D-SNPs' ability to offer supplemental benefits that are critical to meeting the needs of their members. As the MLTSS Association has highlighted in prior comments, supplemental benefits play an elevated role in D-SNPs, which often cover primarily health-related benefits such as adult day care, home-based palliative care, in-home support services, and caregiver supports at higher rates than other traditional MA plans. In many cases, D-SNPs are also subject to State Medicaid Agency Contract (SMAC) requirements to cover certain expanded supplemental benefits as part of their integrated care arrangements. At the same time, D-SNPs must remain competitive in the MA market, which often demands coverage of services not included in Medicare fee-for-service, such as vision, dental, and hearing benefits.

Because Star Ratings performance directly affects plan revenue and rebate levels, changes to the quality rating system that reduce a plan's Star Ratings can have an outsized effect on D-SNPs' ability to sustain and expand supplemental benefits. These dynamics increase the risk of benefit crowd-out and may ultimately undermine CMS' broader goals of promoting integrated, person-centered care and addressing social drivers of health for dually eligible individuals.

Critically, we also urge CMS to build in sufficient implementation time between the adoption of any changes to Star Ratings measures and the start of the measurement year. Doing so allows plans to make meaningful programmatic adjustments in alignment with CMS' quality goals, rather than being required to react to changes mid-year or without adequate preparation. This approach is essential to ensuring that metric changes translate into real improvements in care delivery and beneficiary outcomes.

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[6] Haas A., Quigley D., Haviland A., Orr N., Brown J., Gaillot S., Elliott M. Telephone Follow-Up on Medicare Patient Surveys Remains Critical. The American Journal of Managed Care. January 16, 2025;31(1):e26-e30. Available at: https://www.ajmc.com/view/telephone-follow-up-on-medicare-patient-surveys-remains-critical

[7] Sorbero, M. and Paddock, S. Adjusting Medicare Advantage Star Ratings for Socioeconomic Status and Disability. The American Journal of Managed Care. September 2018. Available at: https://www.ajmc.com/view/adjustingmedicare-advantage-star-ratings-for-socioeconomic-status-and-disability

As CMS considers broader feedback on ways to streamline and modify the Star Ratings methodology and identifies new outcomes measures to promote prevention, wellness, and healthy aging, we encourage the agency to prioritize measures that better reflect care coordination, functional status, and beneficiary well-being for high-need populations. We also encourage CMS to consider how quality measurement can more effectively align with integrated care models and support high-quality outcomes for dually eligible individuals. Finally, as CMS contemplates whether to test Star Ratings-related changes using CMMI demonstrations, we urge the agency not to mandate participation in any such model and to ensure that health plans have meaningful opportunities to provide formal input into the design and development of any potential changes to the Star Ratings program.

Additional Recommendations to Promote Stability and Predictability in Star Ratings

Beginning in 2024, CMS's use of the Tukey outlier deletion methodology in establishing Star Ratings cut points has contributed to the setting of thresholds that, in practice, have proven increasingly difficult for plans to attain. As a result, many high-performing MA organizations experienced declines in their Star Ratings despite no corresponding decline in performance and, in some cases, demonstrated improvement on underlying measures. Medicare beneficiaries rely on the Star Ratings program to make informed decisions about their health coverage options. When plan performance improves but their Star Ratings decline due to the application of statistical methodologies that materially alter cut point calculations, the resulting ratings may no longer accurately reflect true plan performance. This dynamic risks undermining beneficiary confidence in the Star Ratings program and limits individuals' ability to make fully informed enrollment decisions. Further, Star Rating reductions driven by the application of the Tukey outlier deletion methodology have had tangible downstream effects, including the loss of Quality Bonus Payments (QBPs) for otherwise high-performing plans. These reductions have, in turn, contributed to increased premiums and reductions in supplemental benefits available to beneficiaries. Such outcomes are inconsistent with the program's underlying goal of incentivizing quality improvement while maintaining stable and meaningful benefits for Medicare beneficiaries. Therefore, the MLTSS Association recommends that CMS remove the Tukey outlier deletion policy.

Finally, as CMS is considering these proposed changes to the Star Ratings methodology, we would like to reiterate the MLTSS Association's position on Star Ratings changes that CMS proposed but did not finalize in previous rules:

- The removal of the "hold harmless" provision of the Quality Improvement measure for 4-Star plans: CMS originally implemented the Quality Improvement measure to incentivize health plans to improve performance over time. In doing so, the agency appropriately acknowledged the unintended consequence of penalizing plans that had already achieved high levels of performance, as it becomes increasingly difficult to demonstrate statistically significant year-over-year improvement once scores approach the upper end of the scale. To address this concern, CMS established the hold harmless policy to ensure that plans meeting the four-star threshold would not be penalized for only modest gains after achieving consistently strong performance. Notably, CMS communications regarding Star Ratings have consistently characterized plans achieving four or more stars as high-quality options for beneficiaries, reinforcing the four-star threshold as a

meaningful benchmark of success within the program. **Therefore, the MLTSS Association does not support the removal of the "hold harmless" provision of the Quality Improvement measure for 4-star plans.**

- **The removal of guardrails for non-CAHPS measures: The MLTSS Association does not support the removal of guardrails when determining measure-specific thresholds for non-CAHPS measures.** Guardrails serve an essential stabilizing function within the Star Ratings program by providing plans with greater predictability based on known data elements prior to the start of the performance year. Because CMS updates and modifies Star Ratings measures on an annual basis, even relatively small methodological or specification changes can result in substantial fluctuations in performance scores that are not reflective of true or meaningful changes in care delivery. Guardrails help mitigate volatility resulting from year-to-year measure changes and support greater stability in Star Ratings outcomes, which in turn helps ensure beneficiaries experience continuity in plan benefits. In addition, guardrails play an important role in promoting predictability in Quality Bonus Payment (QBP) expenditures and their associated impact on the Medicare Trust Fund. When cut points and QBPs fluctuate significantly from one year to the next, the resulting fiscal impact on the Trust Fund may also become unpredictable. For these reasons, we encourage CMS to carefully consider the role guardrails play in maintaining program stability, beneficiary protection, and fiscal stewardship as the agency evaluates changes to the Star Ratings methodology.

The MLTSS Association appreciates CMS' commitment to continuous improvement of the MA quality framework and welcomes continued collaboration to ensure that the Star Ratings program meaningfully incentivizes high-quality, integrated care for vulnerable populations while supporting the sustainability of D-SNPs that serve them. The MLTSS Association remains ready to support CMS to this end, whether through subject matter expertise, or by convening health plans to discuss these issues.

Improvements for Special Needs Plans

Model of Care (MOC) Off-Cycle Submission Window (42 CFR 422.101)

CMS proposes for CY 2027 and subsequent years that D-SNPs and I-SNPs seeking to revise their NCQA-approved MOC during the MOC approval period must submit updates and corrections between January 1st and March 31st and October 1st and December 31st of each calendar year.

The MLTSS Association supports the updated timelines and appreciates opportunities for earlier off-cycle submissions, as we believe the current June deadline may not provide sufficient time for plans to prepare. With respect to broader forthcoming changes to Model of Care (MOC) requirements, we continue to await updated guidance and urge CMS and NCQA to release the CY 2027 guidelines as soon as possible. Providing sufficient lead time is critical to allow plans to operationalize changes, align care coordination strategies, and ensure continued high-quality service delivery for dually eligible individuals.

Passive Enrollment by CMS (§422.60)

CMS proposes to remove the current passive enrollment requirement at §422.60(g)(2)(ii) that the receiving integrated D-SNPs must have "substantially similar provider and facility networks and Medicare- and Medicaid-covered benefits as the plan (or plans) from which the individuals are passively enrolled." Instead, CMS proposes to require receiving integrated D-SNPs to provide continuity of care for all incoming enrollees for a minimum of 120 days (instead of 90 days). CMS is also proposing to specify that an integrated D-SNP receiving passive enrollment must have the care coordinator staffing capacity to receive dually eligible enrollees through passive enrollment without defining specific staffing level requirements.

The MLTSS Association generally supports these proposed changes and appreciates CMS' efforts to expand and refine passive enrollment policies as a tool for preserving integrated care for dually eligible individuals. **It is the MLTSS Association's position that appropriately designed auto-enrollment policies, including passive enrollment, can play a critical role in increasing participation in integrated care models, reducing fragmentation between Medicare and Medicaid, and improving care continuity and outcomes for individuals with complex medical, behavioral health, and LTSS needs.**

We support CMS' proposal to replace the "substantially similar" network and benefit requirement with a strengthened continuity-of-care standard, as this approach more effectively balances the goal of integration with the practical realities of network design and benefit administration across Medicare and Medicaid. For dually eligible enrollees, preserving access to existing providers, services, and care plans during transitions is essential to maintaining stability, avoiding disruptions in care, and supporting person-centered care delivery. CMS explains that implementing passive enrollment as outlined in §422.60(g), even when the receiving D-SNP meets network adequacy standards, has been hampered by the "substantially similar" network requirement. Extending the continuity-of-care period to at least 120 days supports CMS' goals of minimizing the number of enrollees whose provider relationships are disrupted as a result of passive enrollment while providing a more attainable standard states and D-SNPs can leverage to effectively implement passive enrollment.

The Association also supports CMS' decision to require integrated D-SNPs receiving passive enrollment to have adequate care coordination capacity, while avoiding rigid staffing mandates. Flexibility in staffing models allows plans to tailor care coordination approaches to the unique needs of dually eligible enrollees, state-specific integration requirements, and existing Medicaid LTSS delivery systems, while still ensuring that plans are appropriately resourced to support new enrollees. Taken together, we believe these proposed changes appropriately strengthen CMS' passive enrollment framework in a manner that advances integrated care, promotes continuity and quality, and supports the long-term success of integrated D-SNPs.

Moving beyond passive enrollment, the MLTSS Association recently published a proposal to expand and promote auto-enrollment flexibilities for dually eligible individuals. Historically, CMS has successfully leveraged various forms of auto-enrollment—paired with robust beneficiary protections and guardrails—to increase enrollment into integrated care options. We encourage CMS to build on prior successes, including those demonstrated under the Financial Alignment Initiative with Medicare-Medicaid Plans

(MMPs), to provide states with their choice of pathways to automatically align dually eligible individuals into integrated plans based on existing Medicare or Medicaid enrollment.

The specific enrollment mechanisms of these pathways are:

- When Medicaid enrollment leads:
    - For full benefit dually eligible individuals enrolled in a Medicaid MCO, who are also enrolled in Medicare FFS, grant states additional auto-enrollment authority to automatically align dually eligible individuals to an affiliated integrated D-SNPs in accordance with federal guidelines for beneficiary notice and protections.
- When D-SNP enrollment leads:
    - For full benefit dually eligible individuals who elect to receive Medicare coverage through a D-SNP, encourage states to leverage state Medicaid manage care enrollment authority at 42 CFR 438.54 to auto-enroll these individuals into an affiliated Medicaid MCO when available.

To support aligned enrollment across these pathways, the MLTSS Association supports allowing states the flexibility to implement the auto-enrollment policies that best align with their programs and populations. For any of these pathways, it would be necessary for CMS guidance to ensure consistent application of enrollment authorities, including clear expectations related to beneficiary education, health plan coordination, and timely and transparent notifications.

Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a D-SNP and Medicaid Fee-for-Service (§§422.107 and 422.514)

CMS proposes to amend §§422.107(d)(1) and 422.514(h) to permit MA organizations serving full-benefit dually eligible individuals through a HIDE SNP or coordination-only D-SNP to continue enrolling these individuals when they are enrolled in Medicaid fee-for-service (FFS) in the same service area. In the proposed rule preamble, CMS explains that the proposed changes are intended to "address the challenges of MA organizations complying with the requirements at §422.514(h) in States where there is no mandatory Medicaid managed care program and avoid the need for MA organizations in those States to cease enrolling full-benefit dually eligible individuals who are in Medicaid FFS starting in 2027 and disenroll those members in 2030 as currently required under §422.514(h)." To effectuate these changes, CMS proposes to amend SMAC requirements at §422.107(d)(1) such that any SMACs that allow coordination-only D-SNPs to enroll full-benefit dually eligible individuals must stipulate that such full-benefit dually eligible individuals cannot be enrolled in a Medicaid MCO that is owned and controlled by an entity other than the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization. CMS states that this change would effectively permit coordination-only D-SNPs to enroll full-benefit dually eligible individuals who are enrolled in Medicaid FFS.

Advancing integrated care for dually eligible individuals has been a top priority for the MLTSS Association since its inception. **We continue to support CMS' efforts to improve integrated care delivery through aligned enrollment in D-SNPs, and we appreciate CMS' recognition of the unintended negative**

consequences that the 2027 and 2030 aligned enrollment requirements could have for full-benefit dually eligible individuals enrolled in Medicaid FFS. In response to the CY 2025 MA and Part D proposed rule, the MLTSS Association specifically urged CMS to consider how aligned enrollment requirements could limit access to integrated care models for Medicaid FFS populations, particularly in states where Medicaid managed care is not mandatory for all full-benefit dually eligible individuals or where certain populations are carved out of managed care. In our comments, we cautioned that, absent flexibility, these requirements could force individuals out of D-SNPs into traditional MA plans or Medicare FFS, undermining CMS' stated goals of advancing integration and improving care coordination.

We are encouraged that CMS has taken steps ahead of the 2027 effective date to address these concerns. **However, we are concerned that the proposed regulatory text extends beyond the stated intent described in the preamble and may create confusion for states and health plans as they prepare to implement these policies.** While the preamble frames the proposal as a targeted solution for states without mandatory Medicaid managed care programs, the regulatory language does not include corresponding limitations or qualifiers.

To implement this policy, CMS proposes to codify the following language at §§422.107(d)(1) and 422.514(h)(3):

> ***§422.107(d)(1)(i):***
> *" In conjunction with §422.514(h), to the extent that a State Medicaid agency contract allows a dual eligible special needs plan established through this paragraph (d)(1) to enroll full benefit dually eligible beneficiaries, the contract must stipulate that such full benefit dually eligible beneficiaries cannot be enrolled in a Medicaid managed care organization that is owned and controlled by an entity other than the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization.*
>
> §422.514(h)(3)(iii):
> *"If the State Medicaid agency's contract with the MA organization permits full benefit dually eligible beneficiaries to be enrolled in a plan that is not a HIDE SNP or FIDE SNP per §422.107(d)(1)(i), or a HIDE SNP with the majority of its enrollees in Medicaid fee-for-service, the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization may offer one or more additional D-SNPs for full benefit dual eligible individuals in the same service area."*

In response to this proposed language, the MLTSS Association requests clarification on the following issues:

- Scope and state applicability. The proposed regulatory language does not limit these changes to states without mandatory Medicaid managed care programs or to states with specific Medicaid FFS carve-outs. As a result, the language could be interpreted to apply broadly to all states with SMACs that allow full benefit dually eligible individuals to enroll in coordination-only D-SNPs as well as states that allow enrollment into HIDE-SNPs with the majority of its enrollees in Medicaid FFS. This interpretation appears inconsistent with the intent articulated in the preamble of this

proposed rule and could introduce uncertainty into the implementation of the 2027 aligned enrollment requirements from the CY 2025 MA and Part D final rule. **We encourage CMS to align the regulatory text with their stated intent by explicitly limiting applicability to only states without mandatory Medicaid managed care for all full-benefit dually eligible individuals.**

- Application of the "majority" standard. We also seek clarification regarding the use of the term "majority" in §422.514(h)(3)(iii). Specifically, it is unclear whether CMS intends this standard to apply to both coordination-only D-SNPs and HIDE SNPs, or solely to HIDE SNPs. Additionally, CMS does not specify the percentage threshold that would constitute a "majority." Absent further clarification, this ambiguity may create operational challenges for states and plans, particularly for plans with enrollment levels that fluctuate near any established threshold. In general, we are concerned that introducing an arbitrary numerical threshold could undermine the overall objective of preserving access to integrated care for Medicaid FFS populations. **Consequently, we encourage CMS to consider removing the majority enrollment threshold and instead limit applicability of the proposed changes based on state Medicaid delivery system structure, as discussed above.**

We offer these comments in support of CMS' shared goal of expanding access to integrated care, including its efforts to address alignment challenges in states that continue to operate Medicaid fee-for-service programs. At the same time, the MLTSS Association strongly supports the broader objective of achieving aligned enrollment in integrated care models and encourages CMS to work closely in partnership with states toward that goal. Continued federal-state collaboration will be essential to providing states and plans with the clarity, technical assistance, and flexibility needed to make necessary policy, operational, and delivery system changes while avoiding unintended disruptions to care continuity or quality for dually eligible individuals.

Finally, we support CMS' proposed exemption for MA organizations operating in U.S. Territories, including Puerto Rico, that have not adopted Medicare Savings Programs, from the requirement to only offer one D-SNP for full-benefit dually eligible individuals in a particular service area. We appreciate CMS' recognition of the unique Medicaid structure in the Territories and its efforts to provide flexibility that reflects local program realities.

Contract Modifications for D-SNPs Following State Medicaid Agency Contract Termination (§422.510)

CMS proposes to establish at §422.510(a)(4) CMS may terminate an MA contract when an MA organization is no longer eligible to offer a D-SNP because it does not hold a contract with the State Medicaid agency that meets the requirements of §422.107(b). CMS explains that the purpose of this proposal is to codify the loss of a SMAC as a valid basis for MA contract termination under existing CMS authority. In the preamble, CMS also describes its proposal at §422.510(b)(2)(i)(D) to codify a new policy providing that when a D-SNP contract is terminated because the State has terminated the SMAC **or the affiliated Medicaid MCO contract**, CMS may effectuate immediate termination of the MA contract.

The proposed regulatory text provides that contract termination would be immediate when the MA organization "is no longer eligible to offer a dual eligible special needs plan because the MA organization does not hold a contract consistent with §422.107(b) with the State Medicaid agency." Section 422.107(b) currently establishes the general requirement that MA organizations offering D-SNPs must hold a contract with the State Medicaid agency, while §§422.107(c) and (d) describe the specific requirements and permissible structures of those contracts.

The MLTSS Association agrees with CMS that the termination of a SMAC should constitute a valid basis for terminating a D-SNP's MA contract, as the SMAC is foundational to the operation of a D-SNP and to the delivery of integrated Medicare and Medicaid benefits. We also recognize CMS' interest in ensuring that contract terminations occur in a timely manner when a D-SNP is no longer able to meet statutory and regulatory eligibility requirements. **However, we are concerned that the preamble discussion regarding termination of an affiliated Medicaid MCO contract introduces a broader policy change that is not clearly reflected in the proposed regulatory text and could have unintended consequences for dually eligible individuals.** While the regulatory language ties immediate termination to the loss of a SMAC, the preamble suggests that CMS intends to apply immediate termination authority when an affiliated Medicaid MCO contract is terminated, even where the SMAC itself remains in effect. If implemented as described in the preamble beginning in 2027, this approach could result in the immediate termination of coordination-only D-SNPs or HIDE SNPs that continue to serve partial-benefit or otherwise unaligned dually eligible individuals in states that have not yet fully transitioned to exclusively aligned enrollment.

The MLTSS Association understands CMS' concern that delays in terminating a D-SNP following the loss of an affiliated Medicaid MCO contract could disrupt access to Medicaid benefits for exclusively aligned enrollees. However, applying an immediate termination policy uniformly in these circumstances would also disrupt care coordination and coverage for other enrollees who would not otherwise experience a loss of Medicaid benefits as a result of the affiliated Medicaid MCO contract termination. Although CMS policy will require D-SNPs operating in service areas with affiliated Medicaid MCOs to limit new enrollment beginning in 2027 to dually eligible individuals enrolled in the affiliated Medicaid MCO, many D-SNPs will continue to serve a mixed enrollment population for several years, including both aligned and unaligned members, until unaligned members are fully phased out in 2030. Immediate termination of a D-SNP due solely to the loss of an affiliated Medicaid MCO contract could therefore result in the abrupt loss of MA coverage for unaligned enrollees, including individuals enrolled in unaffiliated Medicaid MCOs, partial-benefit dually eligible individuals, and individuals receiving FFS Medicaid in states where Medicaid managed care enrollment is voluntary.

In these circumstances, termination of the affiliated Medicaid MCO contract would not necessarily prevent the D-SNP from continuing to meet its obligations to coordinate Medicare and Medicaid benefits under §422.2 or from supporting CMS' broader goals of continuity of coverage and beneficiary stability. Accordingly, the MLTSS Association encourages CMS to clarify the relationship between the preamble discussion and the proposed regulatory text. Immediate termination authority should appropriately distinguish between the loss of a SMAC and the loss of an affiliated Medicaid MCO contract, while avoiding unnecessary disruption for dually eligible individuals during the transition to fully aligned enrollment. **We urge CMS to limit this termination proposal to the loss of a SMAC only, and not the loss of an affiliated**

Medicaid MCO contract. We also recommend that CMS allow additional time for terminated D-SNPs to send out enrollee notices, to minimize beneficiary confusion. Further, we encourage CMS to define "immediate" in practical terms—such as a mutually agreed-upon termination date between CMS and the D-SNP—that provides a minimum of 60–90 days for plans to transition beneficiaries in these circumstances. This approach would help protect continuity of care, support integrated plan operations, and ensure stability for dually eligible individuals.

More broadly, SMAC development and maintenance are high priorities for MLTSS Association members and are directly relevant to the operational feasibility and timing of any contract termination policy. We greatly appreciate the technical assistance CMS has provided to states to encourage early and meaningful engagement with plans regarding SMAC changes, particularly given the misalignment between federal and state contracting timelines and approval processes. We recognize that state capacity to proactively manage SMAC development and revisions is limited, and CMS leadership in this area has been critical. In 2025, the MLTSS Association published a resource identifying common SMAC challenges for states and health plans, including tensions between state and federal contracting deadlines. In a subsequent resource, the Association published a recommended SMAC Development Timeline outlining key milestones and recommended timeframes for the development, revision, and annual approval of SMACs. We welcome the opportunity to continue working with CMS on the development of additional resources, guidance or technical assistance documents that may be helpful for states and health plans to streamline the SMAC development process.

Limitation on D-SNP-Only Contracts Submitting Materials Under the Multi-Contract Entity Process (§§422.2261 and 423.2261)

CMS proposes to add a requirement at §§422.2261(a)(3) and 423.2261(a)(3) that MA organizations offering D-SNPs with exclusively aligned enrollment subject to §422.107(e) must submit all materials for the contract in HPMS under the MA organization's contract number. MA organizations and TPMOs may not submit materials for the contract under the organization's MCE number as described in §§422.2262(d)(2)(i) and 423.2262(d)(2)(i)

The MLTSS Association generally supports this proposal, and we also offer additional operational recommendations to improve consistency and efficiency in the submission process across states. These recommendations reflect ongoing challenges encountered by plans and state regulators.

Currently, the material submission process varies significantly from state to state. For states utilizing HPMS for submission review, there is often limited training and guidance on the system's capabilities and limitations, resulting in confusion among D-SNP state regulators. This has contributed to inconsistent use of HPMS across states, with some states implementing multi-step submission processes that require submission through both their state portal/email and HPMS, which lengthens overall review timelines.

To improve clarity and operational efficiency, we support educating states on HPMS use and establishing a single, standardized review process. Specifically, we recommend:

- **A uniform universal 45-day deeming period** across all states, to address current variation among SMAC contractual requirements by state.

- **A 5-day file-and-use approach or a 10-day review period** for all required materials—including Annual Notice of Change, Evidence of Coverage, and Formulary and Summary of Benefits documents—to prevent delays caused by the 45-day submission timeline.

We also recommend exempting states that do not currently participate in the submission review process, as they may not have an interest in reviewing these materials or the operational capacity to implement new review procedures. Taken together, these recommendations would improve operational consistency, reduce unnecessary administrative burden, and support timely review and approval of materials for D-SNPs, while complementing CMS' proposed HPMS submission requirement.

Request for Information: C-SNP and I-SNP Growth and Dually Eligible Individuals

In this RFI, CMS solicits feedback on a number of questions related to Chronic Condition Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs). To be eligible to enroll in a C-SNP, an individual must have a diagnosis of a specific severe or disabling chronic condition, as defined at §422.2. I-SNP eligibility is limited to individuals who meet the definition of institutionalized and institutionalized-equivalent per §422.2.

SMAC Requirements for Certain C-SNPs and I-SNPs

Over the past five years, enrollment in C-SNPs has increased dramatically, with much of this growth fueled by dually eligible individuals. From 2021 to 2025, the number of dually eligible individuals enrolled in C-SNPs more than doubled to over 200,000 individuals. Between 2021 and 2025, the number of C-SNPS with more than 60% dually eligible enrollment increased from 16 C-SNPs to 66 C-SNPs, a 331% increase in five years. In comparison, the number of I-SNPs has remained relatively steady over the past five years, with total I-SNP enrollment in CY2025 at just over 120,000 individuals. The proportion of dually eligible individuals enrolled in I-SNPs continues to be notable, at about 90%, and has remained consistent over time. In response to the high proportion of dually eligible individuals enrolled in both C-SNPs and I-SNPs in CY 2025, CMS solicits feedback on whether there should be a SMAC requirement for these plans, similar to the existing requirement for D-SNPs.

The MLTSS Association supports the highest possible level of integrated care for dually eligible individuals, which requires coordination between MA plans and the State Medicaid agency, and we appreciate CMS' attention to this issue. However, the SMAC development and approval process is administratively complex and resource-intensive for states, and **we do not support expanding SMAC requirements at a time when state administrative capacity remains constrained.** This approach risks diverting limited state capacity away from higher-value integration priorities, including expansion of FIDE-SNPs and HIDE-SNPs, exclusively aligned enrollment, and default enrollment. CMS already has the ability to use more focused and effective tools to address enrollment of dually eligible individuals in non-integrated SNPs—such as enrollment composition thresholds, marketing guardrails, transparency requirements, and non-renewal authority—without creating a new, duplicative contracting requirement. CMS' objectives are best advanced by reinforcing D-SNPs as the exclusive platform for Medicare–Medicaid integration and focusing oversight efforts accordingly.

In 2025, the MLTSS Association published multiple resources on SMAC development and common challenges faced by states and health plans, including tools designed to support more efficient SMAC planning and approval. We welcome the opportunity to discuss these challenges, as well as our Recommended SMAC Development Timeline, in more detail with CMS. Additionally, we believe that there may be other pathways through which CMS can encourage meaningful care coordination for dually eligible individuals enrolled in C-SNPs and I-SNPs that are less administratively burdensome than SMACs, and we encourage CMS to explore these alternatives.

New Care Coordination and MOC Requirements for C-SNPs and I-SNPs

In this RFI, CMS also solicits comment on methods to improve care coordination for dually eligible individuals enrolled in C-SNPs and I-SNPs, noting that the care coordination requirements for D-SNPs are more stringent than those for other types of SNPs. Specifically, CMS asks if they should (a) adopt any new care coordination requirements for dually eligible C-SNP and/or I-SNP enrollees; (b) add any MOC requirements for these SNP types; and (c) what those care coordination or MOC requirements should include.

Applying Look-alike Contracting Limitations to C-SNPs and I-SNPs

Current CMS regulations limit the percentage of dually eligible individuals that can be enrolled in a traditional MA plan to 60%. If a traditional MA plan crosses this threshold, CMS will no longer enter into or renew a contract with that plan. The intent of this threshold was to limit the number of MA plans functioning as D-SNP "lookalikes" – plans that enroll a high percentage of dually eligible individuals that are not subject to D-SNP-specific requirements. In this RFI, CMS requests feedback on whether C-SNPs and I-SNPs that enroll similarly high percentages of dually eligible individuals should be subject to the same restrictions.

We appreciate CMS' commitment to, and continued focus on, improving our integrated care delivery system for dually eligible individuals. **The MLTSS Association remains committed to building on the D-SNP framework as the fundamental, permanent vehicle for delivering integrated care.** We support CMS' careful consideration of the impacts of any contracting limitations for C-SNPs and I-SNPs on dually eligible individuals who have chronic or disabling conditions and/or require an institutional level of care, given the inherent overlap between these populations.

Also in the RFI, CMS acknowledges that one challenge with this proposal is that many C-SNPs do not have a D-SNP in the same service area, and imposing these requirements may inadvertently push individuals from C-SNPs into traditional MA plans or FFS Medicare. To combat this, CMS proposes to exclude partial duals from any "lookalike" calculation, which would reduce the number of C-SNPs subject to transition. **The MLTSS Association supports this proposal and encourages CMS to exclude partial dually eligible individuals from the lookalike calculation in all scenarios, including the existing D-SNP lookalike policy applied broadly to non-SNP MA plans.**

CMS also proposes to only apply the lookalike threshold to C-SNPs in states with integrated D-SNPs, to help prevent disenrollment from C-SNPs into non-SNP MA plans or FFS Medicare. **The MLTSS Association agrees**

with this approach and would only support the transition of dually eligible individuals out of C-SNPs if there were integrated plans available to them. We also encourage CMS to consider allowing new crosswalking flexibilities for individuals enrolled in C-SNPs that cross the lookalike threshold so that members can be seamlessly transferred from a C-SNP to a D-SNP offered by the same parent organization. The impact of this transition on capitation rates and Star Ratings cut points for the D-SNP plan would necessarily shift relative to the condition covered by the C-SNPs. We also appreciate CMS' consideration of the impacts of these potential contracting limitations on individuals in states where integrated D-SNPs do not operate.

Network Adequacy

Predictable and Transparent Review Timelines

CMS is seeking comments on ways to simplify the overall provider and facility network review process, including the submission process, the exception request process, and the timing and frequency of the reviews.

CMS's current approach to network adequacy reviews, particularly triennial reviews, Health Service Delivery (HSD) table submissions, and network exception requests, does not provide plans with advance notice or predictable timelines. Plans are frequently required to respond to new data releases or submission requests with short turnaround times, sometimes as little as 48 hours. For example, CMS has released updated provider supply files on the same day that HSD submission "gates" open, leaving plans with approximately one week, or less, to review substantial changes, reassess network gaps, coordinate internally with contracting and network teams, and finalize HSD tables. In some instances, plans have been required to submit network exception materials within a two-day window. These compressed timelines materially hinder plans' ability to ensure data accuracy and completeness. They also increase the likelihood of downstream issues, including the need for supplemental exceptions or corrective submissions that could have been avoided with modest advance notice.

The MLTSS Association recommends that CMS establish and publish a clear, standardized annual timeline for network adequacy reviews, including anticipated release dates for provider supply files, time and distance standards, and HSD submission windows. We recommend CMS provide advance notice of at least ten business days before releasing new or revised data that materially affects network adequacy determinations. We also recommend CMS provide MA organizations sufficient time—one to two weeks—for submissions.

Modernized Network Exception Template

The current network exception template also presents significant operational challenges that rely on dated technology and processes. The template requires plans to manually enter provider-level details—often hundreds of individual providers—into a static, field-by-field PDF form that does not support bulk data entry, copying, or pasting from structured data sources such as Excel. This design is particularly problematic when plans contract at the group level but are required to list each individual provider separately, sometimes across multiple service locations. The process is extremely time-consuming and increases the risk of human error.

The MLTSS Association recommends that CMS **modernize the network exception submission process by either releasing the exception template in an Excel or other structured, machine-readable format or by allowing plans to submit an Excel attachment containing provider-level details in lieu of manual PDF entry.** These changes would significantly reduce unnecessary administrative burden, improve data accuracy, and enhance CMS's ability to review submissions efficiently.

Conclusion

The MLTSS Association appreciates the work CMS has done in this proposed rule to improve experiences for dually eligible individuals. As the leading association representing MLTSS plans in the United States, we share CMS' desire to address fragmentation in the healthcare system to improve the experiences of dually eligible enrollees in integrated plans. We welcome the opportunity to work with CMS to operationalize the policy changes proposed in this rule.

Sincerely,

Sharon Alexander
Chair, The National MLTSS Health Plan Association Board of Directors