FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

January 17, 2025

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016.

Submitted electronically via regulations.gov

Re CMS-4208-P: 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

Dear Administrator Brooks-LaSure:

As a leading national, nonpartisan voice for health care consumers, Families USA appreciates the opportunity to comment on the *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* (i.e., the 2026 Medicare Part C and Part D proposed rule). For more than 40 years, Families USA has committed to guaranteeing that families and individuals throughout the nation have access to high-quality, affordable, comprehensive health coverage and care that improves overall health – which includes ensuring that older adults and all those who rely on Medicare for their health care have access to high-quality care and coverage options.

The high and rising cost of health care is a profound health problem and a significant economic burden on our nation's families, including for people who rely on Medicare and in particular Medicare Advantage and Medicare Part D for their health coverage.

Large drug corporations too often seek to maximize their profits by raising prices of both existing and new prescription drugs to obscene, price gouging levels. Drug companies have amassed significant market and monopoly power, regularly buying up or paying off their competition in order to game the U.S. patent system and charge inflated prices for prescription medications. As a result, U.S. drug prices paid by Medicare are two to four times higher than prices in other comparable countries, even after rebates.[1] And millions of Medicare beneficiaries who rely on Medicare Part D for coverage and access to their prescription drug medication, including lower-income and rural beneficiaries, struggle to obtain the prescription medications that they need due to the high cost.[2]

At the same time, insurers participating in Medicare Advantage – a program that gives people the option to receive their Medicare Part A and B benefits through private plans – too often engage in harmful business practices that drive low-value care for patients and wasteful spending in the Medicare program which harms the health and financial wellbeing of beneficiaries.[3] Medicare Advantage (MA) insurers engage in a number of practices that harm older adults including predatory and deceptive marketing schemes to prospective beneficiaries, overly aggressive and medically inappropriate care denials, and systematic upcoding of patient diagnoses that do not reflect the actual care that beneficiaries are receiving, among other abuses.[4] Collectively, these practices deprive beneficiaries of access to medically

necessary care when they need it most, raise Part B premiums for everyone, and contribute to hundreds of billions of dollars in wasteful Medicare spending without delivering better health care quality or coverage to our nation's older adults.[5]

The 2026 Medicare Part C and Part D proposed rule includes significant policy and technical changes related to the coverage and administration of the Medicare Advantage and Medicare Part D programs, which would have significant implications for the health and health care coverage of the over 30 million people who rely on Medicare Advantage and the 53 million people who rely on Medicare Part D for their medical care and prescription drug coverage, respectively.[6]

Families USA offers comments on six proposals that we believe are particularly important and relevant to ensuring our nation's families have access to affordable and high-quality coverage and care, specifically through improved access to prescription medications and better accountability for MA insurers to deliver on their obligations to provide affordable and quality coverage options. Our comments also focus on the critical need for CMS to end wasteful and inefficient spending and low-value care by reining in the ability of MA plans to **systematically upcode patient diagnoses without evidence of improved patient care.**

1. *Section A. Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices under Medicare Part D (§§ 423.100 and 423.120)*
2. *Section B. Appropriate Cost-Sharing for Covered Insulin Products under Medicare Part D (§§ 423.100 and 423.120)*
3. *Section O. Promoting Informed Choice—Expand Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap (§§ 422.2274 and 423.2274)*
4. *Section Q. Promoting Informed Choice- Enhancing Review of Marketing & Communications (§§ 422.2260 and 423.2260)*
5. *Section T. Proposed Regulatory Changes to Medicare Advantage (MA) and Part D Medical Loss Ratio (MLR) Standards*
6. *Section F. Comment Solicitation- Making State Medicaid Agency Contracts Public*

A. Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices under Medicare Part D (§§ 423.100 and 423.120)
B. Appropriate Cost-Sharing for Covered Insulin Products under Medicare Part D (§§ 423.100 and 423.120)

The Inflation Reduction Act (IRA), passed in 2022, was landmark legislation that took important strides in improving affordable prescription drug access for millions of older adults and people with disabilities. The IRA works to tackle high and rising drug costs by allowing the federal government to negotiate directly with drug companies for a fair price on some of the most expensive medications in Medicare. The Medicare Drug Price Negotiation Program recently negotiated the first 10 drugs — drugs used to treat common conditions like diabetes, Crohn's disease, arthritis, blood clots and more — which will create an estimated $6 billion in savings for Medicare while ensuring lower costs for people at the pharmacy counter when new prices take effect in 2026.[7] In addition to lowering the cost of some drugs upfront, Medicare now has the power to take action against drug companies that are hurting patients by setting irrational and unjustifiable high prices. In 2023, the IRA saved older adults as much as $618 per average dose on 47 different prescription drugs due to the law's requirement that drug companies pay rebates on certain drugs if prices outpace the rate of inflation.[8]

The IRA also included critical provisions that ensure our nation's older adults have affordable access to life-saving medications such as vaccines and insulin products. Specifically, the IRA directed the U.S. Department of Health and Human Services (HHS) to require that Part D plans not apply any deductible or cost-sharing for an adult vaccine as recommended by the Centers for Disease Control Advisory Committee on Immunization Practices (ACIP) beginning on January 1, 2023. Moreover, the IRA directed HHS to require Part D plans not to apply a deductible to covered insulin products and mandated that cost-sharing for a one-month supply of each insulin product may not exceed $35.[9]

Importantly, the IRA provided HHS with the needed statutory authority to implement such provisions using sub regulatory "program instruction or other forms of program guidance" for CY2023, CY2024, and CY2025. After CY2025, CMS is subject to additional requirements under the Administrative Procedures Act (APA) and is required to provide a formal notice and comment period on any proposed rules or regulations related to implementing new or existing law, including the provisions of the IRA as described above.

In the Medicare Part C and Part D proposed rule for CY2026, CMS proposes to codify in federal regulations the provision that directs Part D plans to waive all cost-sharing and deductibles for ACIP approved vaccines as well as the provision to cap cost-sharing for covered insulin products to $35 for a one-month supply. Families USA strongly supports codifying these IRA provisions into federal regulation, as they are critical to ensuring our nation's older adults and all those who rely on Medicare have affordable access to life-saving insulin and vaccines for years to come. Codification enshrines these IRA provisions into the code of federal regulations and as such will have full legal effect in holding Part D plans and sponsors legally accountable to implementing such provisions.[10] Moreover, codification means that any future proposed changes to the regulation, including those that may harm patients' access to affordable life-saving insulin or vaccines, will require a formal notice and comment period per APA rules.[11]

The importance of codifying these provisions cannot be overstated. Vaccinations are essential public health measures that protect our nation's families against preventable illness. Since 1974, vaccines have saved a staggering 154 million lives.[12] Yet over 25% of older adults in the U.S. are unable to access life-saving vaccines due to the high cost.[13] Preserving access to affordable vaccines is not only a cornerstone of any high-value health care system but is also an essential component of effective national security by safeguarding the American people from current and future global health threats.[14] Moreover, one-third of Medicare beneficiaries have diabetes and over 3.3 million take insulin as part of their treatment.[15] Yet, in 2021 alone, over a million Americans were forced to ration their insulin due to the high cost.[16] Overall, almost 30% of Americans are not taking their medications as prescribed specifically due to cost — rationing their medications, skipping doses, or not filling their prescriptions at all.[17] Being forced to make those decisions directly results in poorer health outcomes: rationing or skipping needed medication causes an estimated 125,000 deaths a year.[18]

As such, Families USA strongly supports formal codification of these provisions into the code of federal regulations as required under the APA, ensuring continued implementation of $0 cost-sharing for certain adult vaccines and limiting cost-sharing for covered insulin in Medicare Part D to $35.[19]

O. Promoting Informed Choice—Expand Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap (§§ 422.2274 and 423.2274)
Q. Promoting Informed Choice- Enhancing Review of Marketing & Communications (§§ 422.2260 and 423.2260)

Families USA strongly supports CMS' proposals in the 2026 Medicare Part C and D proposed rule to strengthen certain beneficiary protections against aggressive and deceptive marketing practices by MA insurers and their brokers.[20] Specifically, CMS proposes to require MA agents and brokers to discuss with beneficiaries the potential impact that enrolling into an MA plan can have on their ability to access an affordable Medigap plan in the future, including by foregoing certain pre-existing condition protections after a certain period of time post MA enrollment.[21] Moreover, CMS proposes to broaden its definition of MA-related "marketing materials" that are subject to CMS review and pre-approval to ensure the vast majority of MA-related communications to beneficiaries receive CMS oversight to ensure they are not misleading or confusing.[22] Specifically, CMS is removing the "content standard" from the definition of MA marketing materials that are subject to CMS pre-approval and oversight. As a result, certain advertisements and other beneficiary communications that previously did not meet CMS' "content standard" (i.e. do not mention an MA plan's specific "benefit structure, cost sharing, measuring or ranking standards") but otherwise were intended to "draw a beneficiary's attention to a plan or influence a beneficiary's [enrollment] decisions" will now be subject to CMS oversight and approval under this proposal.[23]

There is longstanding evidence that MA insurers use deceptive and misleading tactics, often through third party broker or advertising firms, to persuade older adults to enroll in an MA plan instead of Traditional Medicare.[24] In some cases, MA insurers or their agents make completely false or misleading statements when they market MA plans.[25] Insurance brokers have gone so far as to lie to older adults, promising them that their doctors are covered by an MA plan only for those older adults to learn months later that their doctor is in fact out-of-network and they will have to pay out-of-pocket to visit their doctor.[26] When older adults go to use their coverage, they often find the benefits a plan promised to cover differ from what is actually available.[27] For instance, nearly 60% of MA brokers promise prospective beneficiaries they can keep their doctors if they enroll in their plan despite the fact the vast majority of MA plans have restrictive provider networks that do not cover out-of-network care and often exclude an enrollee's pre-existing provider.[28]

MA insurers' aggressive and deceptive marketing is particularly pernicious as it can ultimately trap our nation's older adults in the MA program due to an existing loophole that deprives them of their ability to seek alternative coverage options in the future.[29] Importantly, 46 states do not require Medigap plans to sell insurance to someone with pre-existing conditions above and beyond certain federal pre-existing condition protections (which only apply if the Medigap plan is purchased during the first six months of their initial Medicare enrollment).[30] As a result, certain patients with complex care needs in Medicare either have no access to care or are exposed to higher cost sharing due to being charged significantly higher premiums. [31,32] This means that MA beneficiaries who get sick and realize Traditional Medicare would provide more comprehensive coverage to meet their health needs are severely limited in options. They may not be able to buy a Medigap plan that can cover their significant levels of cost sharing, including the 20 percent co-insurance charged for most medical services with no out-of-pocket

maximum that Traditional Medicare requires by default.[33] This major loophole in the Affordable Care Act's pre-existing condition protections can make it unaffordable for certain patients with complex care needs to move into Traditional Medicare from the Medicare Advantage program. Importantly, there is substantial evidence that MA insurers and brokers do not explain this critical nuance to prospective beneficiaries who are weighing whether to enroll in an MA plan or into Traditional Medicare, leading to significant confusion.[34] This severely undermines healthy competition between the MA program and Traditional Medicare since patients cannot effectively shop between MA and Traditional Medicare to determine which coverage option is best for them and their family.

Considering MA insurers' longstanding practice of engaging in deceptive and misleading marketing practices, **Families USA strongly supports both of these proposals to strengthen CMS oversight of MA-related marketing, including subjecting a larger universe of MA-related communications and marketing materials to CMS oversight and ensuring MA agents and brokers are informing beneficiaries of potential challenges with Medigap-related protections and how they may be at risk post MA enrollment.** These are important steps to ensuring our nation's older adults and all those who rely on Medicare coverage for their health and health care can make informed coverage choices that are best for them and their families.

T. Proposed Regulatory Changes to Medicare Advantage (MA) and Part D Medical Loss Ratio (MLR) Standards

Medical loss ratio (MLR) requirements are critical patient safeguards to ensure that the majority of health care dollars go towards covering the health and health care related needs of our nation's families as opposed to health insurer administration or profits.[35] These requirements were put in place under the Affordable Care Act and establish a fixed percentage of premium dollars that insurance companies are required to use to cover health-related expenses.[36] In the Medicare Advantage program, MA insurers are required to spend at least 85 percent of their revenues – revenues which primarily come from risk-adjusted Medicare payments – on patient care.[37] Patient care includes all medical-related health care claims (i.e., insurer payments to providers for covered medical care as well as any payment based incentives or bonuses to providers, including from risk-sharing agreements), prescription drug costs if an MA plan offers a prescription drug benefit, spending used to subsidize Part B premiums, and costs related to health care quality improvement activities.[38] CMS requires MA insurers to submit a standardized MLR report for each contract year that includes the data needed to verify they have satisfied all MLR requirements; importantly, if CMS finds an MA insurer did not meet the MLR, the insurer needs to pay CMS the value of the revenue that was inappropriately used towards non-medical costs.[39]

In the CY2026 proposed rule, CMS proposes to make a number of important changes to MLR reporting requirements for Medicare Advantage insurers. Families USA offers comments on proposals 2, 3, and 8 included in Section T as outlined below.

<u>2. Proposal to Require Clinical or Quality Improvement Standards for Provider Incentive and Bonus Arrangements to be Included in the MA MLR Numerator (§ 422.2420)</u>

Families USA strongly supports CMS' proposal to establish additional quality standards and requirements for MA insurers when they are reporting certain incentives and bonus payments as

medical spending for the purposes of MLR reporting. Insurers that negotiate certain non-Fee-for-Service (non-FFS) payment models or other risk sharing arrangements with their contracted providers are required to report that spending under a distinct subcategory of medical spending – "provider incentives and bonus payments" – for the purposes of MLR reporting.[40] CMS proposes to require that insurers can only report such provider incentives and bonus payments if those payments are tied to "clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.[41]

Currently, incentive and bonus payments made to providers can be included as medical spending (i.e., towards the MLR numerator) regardless of whether they are tied to clinical or quality improvement standards for providers.[42] The proposed rule builds on similar requirements that were put in place under MLR reporting requirements for Medicaid and CHIP plans, as well as commercial insurers.

As noted above, MLR requirements are critical patient safeguards which ensure health care dollars are spent on patient care rather than towards health care industry revenues and profits. Yet, there are significant concerns that large insurance corporations, including those participating in the individual MA market, are gaming current MLR report requirements to maximize their profits and revenues to the detriment of providing high value care and coverage to their patients. In part, experts have suggested that MA insurers may be negotiating faux "value-based contract" agreements with their affiliated providers that involve transferring a share of the insurers' premium revenue over time.[43] Not only does this have the effect of artificially inflating an insurers reported medical spending for the purposes of MLR reporting, it allows insurers to game the Medicare payment system to drive higher risk-adjusted payments.[44]

Since Medicare pays MA plans a monthly fixed capitated payment to cover the expected health care costs of their beneficiaries, and those payments are risk-adjusted based on the health status and medical diagnoses of each enrolled patient, more diagnoses added to a patient's medical record directly results in more money for the insurer.[45] These premium sharing arrangements between insurers and providers act to impose misaligned financial incentives in the MA payment system from MA insurers onto providers so they financially benefit by engaging in corporate coding abuses and assigning patient diagnoses to the greatest extent possible – even if those diagnoses are not supported by a patient's medical record and don't result in *any* additional care or coverage to Medicare beneficiaries.[46]

As noted previously, these harmful coding practices drive billions of dollars in CMS overpayments annually, higher Part B premiums that are borne by Medicare beneficiaries across the Medicare Program and undermine the MA program's ability to deliver meaningful high-value and high-quality care and coverage options to our nation's families.

As such, we strongly support CMS' proposal to require that incentive and bonus payments, as reported by MA insurers for the purposes of MLR reporting, are *directly* linked to well-documented clinical or quality improvement standards. This proposal is a critical first step in holding MA insurers accountable and to help rein in a key strategy that MA insurers use to engage in corporate coding abuses to maximize their payments without delivering commensurate care or coverage to our nation's families. No longer can MA insurers simply pay providers to code more diagnoses by putting in place faux value-based contracts or other financial incentives solely based on coding intensity and upcoding, without risking MLR related penalties or claw backs. **Moreover, we applaud CMS for finalizing similar**

MLR requirements in previous rulemaking applied to commercial insurers and Medicaid managed care plans.[47]

3. Proposal to Prohibit Administrative Costs from Being Included in Quality Improving Activities in the MA and Part D MLR Numerator (§§ 422.2430 and 423.2430)

Families USA also supports CMS' proposal to strengthen MLR requirements for MA insurers reporting expenses related to health care quality improvement. As noted above, CMS allows MA insurers to report expenditures related to quality improvement activities – along with medical expenses – for the purposes of MLR reporting. Specifically, these health care quality activities must be designed to improve health outcomes, prevent hospital readmissions, improve patient safety, promote health and wellness, or enhance the use of health care data to improve quality, transparency, and outcomes. Moreover, these quality related activities must be designed to improve health quality, increase the likelihood of desired health outcomes in objective and measurable ways, and be directed to individual beneficiaries or groups of beneficiaries and be grounded in evidence-based medicine.[48] However, CMS MLR rules do not outline the specific types of expenses that may be reported as a quality-related expense, including to what extent the spending must relate *directly or indirectly* to quality improvement activities as described above. CMS proposes to specify that "only expenditures *directly* related to activities that improve health care quality may be included as "quality improving activity expenses" for the purposes of MA MLR reporting.[49]

We support CMS' proposal to specify to what extent MA insurer spending related to quality improvement can be reported in the numerator of MLR reporting. It is critical that health care dollars, including Medicare payments to MA insurers, are primarily spent on providing high quality and affordable care and coverage, and these additional requirements are an important albeit incremental step in using MLR requirements to uphold such a standard. **At the same time, we urge CMS to go further in specifying what constitutes "quality improvement activities" for which related expenses must be included in MLR reporting.**

It is well documented that MA insurers upcode and assign erroneous patient diagnoses to maximize their risk-adjusted Medicare payments, using sham chart reviews and health risk assessments that too often are not medically supported (i.e., not supported by the patient's medical record) or do not result in any additional medically necessary treatment or care.[50] It is these very chart reviews and health risk assessments that are misleadingly described as improving health care quality for Medicare patients by "identifying gaps in care" as suggested by MA industry stakeholders.[51] Yet more than half of the conditions discovered through these tactics do not result in beneficiaries receiving *any* additional treatment or care, and drive up to $10 billion of wasteful Medicare spending every year.[xxxvi]

Given the substantial track record of MA insurers engaging in corporate coding abuses and other gaming efforts, additional transparency and oversight of MLR reporting by MA insurers is essential to ensure MA insurers are not reporting such harmful tactics as "quality improvement activities." **As such, we recommend that CMS strengthen MLR reporting requirements that expand the MLR related information that is reported by MA insurers to CMS and is made public, including requiring MA insurers to report additional detail on what *specific* activities MA insurers are treating as "quality improvement activities". We also recommend CMS proactively exclude spending related to well documented and harmful behaviors that drive wasteful and low-value Medicare spending from the definition of "quality improvement activities" for MLR reporting purposes, including the use of chart reviews and health risk assessments that do not result in additional care or coverage.**

8. Request for Information on MLR and Vertical Integration

In addition to proposing new MLR reporting requirements, CMS is soliciting public comment on whether they could and should adopt additional policies that help address MLR reporting compliance among vertically integrated health insurers and health systems.

As observed across the health care system, there is growing consolidation among insurers that offer MA plans. There is intensifying horizontal consolidation between MA organizations, with only a handful of insurance companies projected to enroll the vast majority of MA beneficiaries in 2024 – including UnitedHealthcare (29%), Humana (18%), Blue Cross Blue Shield (14%) and CVS Health (12%).[52] And, importantly, there is growing vertical integration between MA organizations and health care providers; UnitedHealthcare for instance employs almost 50,000 physicians as of 2021, and their reported share of medical expenses that flow to employed providers or other related businesses increased nearly 250% between 2016 and 2019.[53]

As noted by CMS and others, vertically integrated MA plans may be more likely to circumvent or game MLR requirements.[54] Plans can potentially game these requirements by vertically integrating with physician and other provider groups.[55] Specifically, provider practices are not subject to MLR requirements so once an insurer owns a provider group they can pay themselves by paying their vertically integrated providers above-market rates for health-related services and reporting those inappropriately high payments as a medical cost for the purposes of MLR reporting – even though it represents additional profit for the parent company.[56] Therefore, plans can steer a greater proportion of their premium dollars above and beyond the capped rate per the MLR requirement through their vertically integrated provider groups.[57] Some estimates suggest that in plans who own and employ health care providers and are vertically integrated could be spending as little as 70% of their premium dollars on patient care.[xlv]

There is also evidence suggesting that vertically integrated MA plans are more likely to engage in systematic upcoding, which is a major driver of low-value care and wasteful Medicare spending and is harmful to both Medicare beneficiaries and taxpayers alike.[58] These plans put financial incentives in place (similar to those as described in proposal 2 above) that act to pressure their employed or affiliated providers to diagnose their beneficiaries with additional or even erroneous diagnoses to secure higher risk-adjusted payments from CMS.[59] As a result, vertically integrated plans have been found to generate 16% higher risk scores for the same patients compared to Medicare FFS, which is nearly three times the effect among non-vertically integrated plans.[60]

As such, we strongly urge CMS to explore reforms to mitigate the harms related to vertically integrated plans and ensure health care dollars are spent on the health and health care of our nation's families. These reforms could include:

1. **Putting in place stronger MLR and MLR-related transparency and reporting requirements that require vertically integrated insurers to report their transfer prices and their overall MLR for the provider group and the parent company for their Medicare beneficiaries;[61] and**

2. **Establishing pricing benchmarks on transfer prices to ensure vertically integrated insurers are paying the same fair market rates to their affiliated and employed providers as they do to unaffiliated providers.[62]**

We also strongly recommend that CMS take additional action in future rulemaking, including the CY2026 MA and Part D Advance Notice and Rate Announcement, to rein in the systematic upcoding and overpayments observed in the Medicare Advantage program.

Specifically, we recommend CMS enact the following changes:

- Apply a higher coding adjustment factor above and beyond what is minimally required in statute to fully account for intensive coding by MA plans, using a tiered approach that targets MA plans who engage in upcoding to the greatest extent in order to remove their unfair advantage as compared to other MA plans.
- Exclude information exclusively collected via in-home health risk assessments (HRAs) or chart reviews as a source of diagnoses for Medicare Advantage risk adjustment scores and payments, which are easily abused and represent a significant driver of coding intensity and upcoding as noted by MedPAC and HHS OIG.[63]
- Use two years of traditional Medicare and MA diagnostic data for calculating MA risk-adjusted payments to avoid allowing erroneous diagnoses, such as those due to errors or inappropriate coding from one particular year, to drive upcoding and overpayments in MA.[64]
- Initiate longer term reforms of the CMS-HCC Risk Adjustment Model that drive towards a health care system that promotes health equity and social and economic wellbeing and delivers whole-person and patient-centered care:
    - Explore alternative sources of data for MA risk adjustment that cannot be easily gamed by industry.
    - Incorporate additional measures of health-related social needs to more accurately account for expected health care costs among socially vulnerable and marginalized populations and drive towards equity and improved protections against adverse selection.

Reforms such as these are critical to ensure that MA insurers are spending the vast majority of their revenues (i.e., their risk-adjusted Medicare payments) on the care and coverage of our nation's older adults and all those who rely on the MA program.

F. Comment Solicitation- Making State Medicaid Agency Contracts Public

Approximately 12.9 million Medicaid beneficiaries are also covered by Medicare, the primary source of health insurance for people ages 65 and older.[65] These joint Medicare-Medicaid beneficiaries are known as dual-eligible individuals.[66] In 2023, 5.2 million dual-eligible individuals were enrolled in an integrated Medicare Advantage plan—called a Dual-Eligible Special Needs Plan (D-SNP)—specifically designed to provide greater care coordination between the two programs.[67]

Every D-SNP must sign a contract with the state, known as the State Medicaid Agency Contract (SMAC).[68] These contracts outline requirements that the plan must meet to ensure Medicare coverage works smoothly with Medicaid coverage (for example, through care coordination or coordinated

reporting requirements), allowing the two programs to feel like one. Where SMACs are constructed to foster effective coordination between Medicare and Medicaid, dual-eligible individuals enrolled in a D-SNP are better able to navigate across the two systems. Contract requirements in SMACs have the potential to enhance member satisfaction, improve outcomes and reduce costs.

However, states have varied success in executing SMACs. In some states SMACs go beyond minimum federal requirements to require greater integration or better tailor how D-SNPs serve dual eligibles. Other states report struggling with how to best use their contracting authority to ensure D-SNPs are responsive to the needs of dual-eligible individuals.[69] Many state Medicaid agencies have limited in-house expertise in Medicare programs and policies.[70] This can make it difficult to effectuate contracts with D-SNPs that get the incentives right to promote adequate integration. Publicly available information on SMACs can reduce this information gap.

To give state Medicaid agencies and other stakeholders the tools to improve effective coordination of care for dual-eligible individuals, **Families USA recommends that CMS collect SMACs from the states or individual D-SNP plans and post them publicly. At minimum, CMS should create a process that makes it easy for stakeholders to request access to SMACs.** Making SMACs publicly available will foster greater public transparency regarding how D-SNPs function, allow states to learn from their peers, and strengthen the ability of state Medicaid agencies to leverage the D-SNP model to improve care for beneficiaries.

Conclusion

Families USA appreciates the opportunity to respond to proposed changes to the Medicare Advantage and Medicare Part D programs for CY 2026. For questions or comments, please reach out to Mary-Beth Malcarney, Senior Advisor on Medicaid Policy (mmalcarney@familiesusa.org) and Aaron Plotke, Senior Policy Analyst (aplotke@familiesusa.org).

Sincerely,

Sophia Tripoli
Senior Director of Health Policy

[1] Mulcahy, Andrew, Christopher Whaley, Mahlet Tebeka, et al. "International Prescription Drug Price Comparisons," Rand Corporation, https://www.rand.org/content/dam/rand/pubs/research_reports/RR2900/RR2956/RAND_RR2956.pdf; See also, Government Accountability Office, Prescription Drugs: U.S. Prices for Selected Brand Drugs Were Higher on Average than Prices in Australia, Canada, and France, GAO-21-282, April 28, 2021.

[2] Tarazi, Wafa, Kenneth Finegold, Steven Sheingold, et al. "Prescription Drug Affordability among Medicare Beneficiaries (HP-2022-03)," ASPE Office of Health Policy, 19 January 2022, https://aspe.hhs.gov/sites/default/files/documents/1e2879846aa54939c56efeec9c6f96f0/prescription-drugaffordability.pdf.

[3] Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game | Health Affairs; See also, HHS OIG, Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments, September 20, 2021. OEI-03-17-00474. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp; Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf; Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (hhs.gov); Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022 | KFF

[4] Ibid; See also, MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY2024_MedPAC_COMMENT_v2_SEC.pdf; Tricia Neuman, Juliette Cubanski, & Meredith Freed, Monthly Part B Premiums and Annual Percentage Increases, January 12, 2022. https://www.kff.org/medicare/slide/monthly-partb-premiums-and-annual-percentage-increases/; CMS, Medicare Savings Programs, https://www.medicare.gov/basics/costs/help/medicare-savings-programs; See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See page 265 of MedPAC, January 2024 Public Meeting Transcript.

[5] Ibid.

[6] Note there are at least 30 million Medicare beneficiaries who are enrolled in a Medicare Advantage plan that *also* includes Part D prescription drug coverage. For more information, see: https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2024/

[7] "Fact Sheet: Biden-Harris Administration Announces New, Lower Prices for First Ten Drugs Selected for Medicare Price Negotiation to Lower Costs for Millions of Americans," The White House, August 15, 2024, https://www.whitehouse.gov/briefing-room/statements-releases/2024/08/15/fact-sheet-biden-harris-administration-announces-new-lower-prices-for-first-ten-drugs-selected-for-medicare-price-negotiation-to-lower-costs-for-millions-of-americans/.

[8] Office of Health Policy, "Inflation Reduction Act Research Series- Medicare Part B Inflation Rebates in 2023," ASPE, December 14, 2023, https://aspe.hhs.gov/sites/default/files/documents/7135bf0b04310aaf69f8c5f3029c4b05/ira-medicare-part-b-rebate-factsheet.pdf.

[9] 42 CFR Parts 417, 422, 423, 460, RIN 0938-AV40, https://www.govinfo.gov/content/pkg/FR-2024-12-10/pdf/2024-27939.pdf; For 2026 and each subsequent year, cost sharing for covered insulin products is the less of 1) $35 or 2) 25 percent of the maximum fair price as negotiated under the Medicare Drug Negotiation Program.

[10] "Agency Use of Guidance Documents," Congressional Research Service, https://crsreports.congress.gov/product/pdf/LSB/LSB10591

[11] Ibid.

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