National
MLTSS
Health Plan Association

April 29th, 2025

Abe Sutton
Director, Center for Medicare and Medicaid Innovation (CMMI)
Deputy Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Gary Bacher
Chief Strategy Officer, Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Director Sutton and Officer Bacher,

Thank you for your commitment to and leadership in guiding the Center for Medicare and Medicaid Innovation (CMMI) through this period of transition. We look forward to continuing to partner with you and your team to improve health care for high-need, high-cost Medicare and Medicaid beneficiaries.

The National MLTSS Health Plan Association (MLTSS Association) represents managed care organizations (MCOs) that provide long-term services and supports (LTSS) within Medicaid through risk-based arrangements with states.[1] Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system, with a particular focus on ensuring individuals' quality of life and independence.

We are writing to discuss the potential impact of the recent Department of Health & Human Services reductions in force on the Medicare-Medicaid Coordination Office (MMCO) within CMS. MMCO was created as an independent entity to develop more coordinated, high-quality, and cost-effective programs for individuals dually enrolled in Medicare and Medicaid. MMCO has a valuable and unique role in supporting states to advance integrated care for these individuals. Specifically, we are inquiring about specific functions MMCO has historically performed, if these will continue and who will be leading them.

Individuals who are dually eligible for Medicare and Medicaid are among the country's most vulnerable populations with complex health, functional, and health-related social needs. They must navigate coverage across both Medicare and Medicaid—two systems not originally designed to work together—which leads to fragmented, duplicative, and uncoordinated care that further exacerbates their health care challenges. Despite making up only 13% of Medicaid and 19% of Medicare enrollment, they account for nearly one-third of each program's costs.

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

National
MLTSS
Health Plan Association

MLTSS Association members are leaders in integrated care - a system that aligns the delivery, payment, and administration of Medicare and Medicaid benefits for individuals who are dually eligible for both programs.[2] There is significant overlap between MLTSS and the dually eligible population - over 60% of individuals who use Medicaid-funded LTSS are dually eligible, and this proportion grows to 95% of Medicaid-funded LTSS users over age 65.[3]

Integrated care is delivered primarily through Dual Eligible Specials Needs Plans (D-SNPs); Medicare Advantage (MA) plans specifically designed to meet the needs of dually eligible individuals. D-SNPs provide enhanced care coordination, comprehensive supplemental benefits, and wraparound services, including LTSS and Behavioral Health. Integrated care streamlines the care delivery system for these individuals, ensuring they receive the care they need while minimizing administrative burden and costs to state and federal governments.

Our support of integrated care and D-SNPs has led to a longstanding relationship between the MLTSS Association and the Federal Coordinated Health Care Office – also known as the Medicare Medicaid Coordination Office, or MMCO. Over the years, we have worked collaboratively with MMCO to ensure that our member plans have the support, information, and technical assistance they need to successfully stand-up and operate their integrated plans. Given the recent staffing changes at MMCO, we want to ensure that these vital functions of MMCO continue, and that there is clear guidance for stakeholders on the correct points-of-contact. Specifically, we are inquiring about the following functions of MMCO. Will these functions continue and who will be responsible for leading?

1. Review of State Medicaid Agency Contracts (SMACs)
    a. MMCO plays a key role in the creation and review of State Medicaid Agency Contracts (SMACs) – contracts between state Medicaid agencies and D-SNPs that outline the terms of their partnership. MMCO ensures that SMACs adhere to federal regulations and support the integration of Medicaid and Medicare benefits.

       SMAC creation, review, and submission is an annual process, culminating with the SMAC submission deadline the first Monday in July. MMCO provides support to both states and D-SNPs as they develop and revise these contracts to ensure timely drafting and completion. MMCO also reviews these contracts after they are submitted to CMS.

2. Meetings with health plans
    a. In addition to providing one-on-one technical assistance to states, MMCO also provides support to health plans who operate, or are interested in operating, integrated plans for dually eligible individuals. Interested plans can schedule regular meetings with MMCO to discuss topics including compliance issues, implications of

[2] What is Integrated Care | Medicare Messenger
[3] Who Uses Medicaid Long-Term Services and Supports? | KFF

policies, CMS rulemaking, and D-SNP bids and readiness. Fostering collaborative relationships between health plans and MMCO improves health plans' ability to offer high-quality integrated care and minimizes administrative burden for both parties. These meetings also keep MMCO informed by providing real-time feedback on what is happening on the ground for health plans serving dually eligible individuals.

3. Production of Health Plan Management System (HPMS) memos related to D-SNPs and Applicable Integrated Plans (AIPs)
    a. MMCO is responsible for the creation of HPMS memos that provide updates and technical assistance on topics related to D-SNPs and dually eligible individuals. For example, MMCO was an author of an April 9th memo that provided instructions for MA plans that are D-SNP "look-alikes" in 2025 on how to transition enrollees, as required, to other plan types for CY2026. Without these timely memos, health plans will not have access to the technical guidance necessary to successfully operate in compliance with current CMS requirements.

4. Technical assistance to states
    a. MMCO provides technical assistance to states to help them coordinate and improve the delivery of care for dually eligible beneficiaries. This assistance is intended to simplify processes, improve quality of care, and ensure dually eligible individuals have full access to their benefits. States can request one-on-one support from MMCO to address specific issues or questions. The **Integrated Care Resource Center** – an initiative of MMCO - provides technical assistance and resources to states and other stakeholders to support their integrated care programs.

    This technical assistance is especially helpful for states that are currently operating Medicare Medicaid Plans (MMPs), demonstrations under the Financial Alignment Initiative (FAI) that will be ending at the end of 2025, per federal requirements. In most states, these MMPs will transition into D-SNPs, which will take a significant investment of time and resources from states, health plans, and the federal government. MMCO's participation and support will be essential to ensuring seamless transitions for dually eligible individuals.

    MMCO provides technical assistance to states and health plans on a number of issues, including assistance and approval of enrollment transactions, such as default enrollment, passive enrollment, and crosswalk authorities. Timely assistance and approval of these enrollment transactions is an essential function of the office. MMCO also provides technical assistance to states and health plans to comply with new requirements for integrated appeals processes.

Regardless of where states are on the continuum of integrated care, technical assistance from MMCO is necessary to ensure smooth compliance with CMS regulatory changes, including the significant changes included in the CY2025 Medicare Advantage and Part D Rule. States and health plans are preparing now for implementation deadlines approaching in 2027 and will require support and technical assistance from MMCO over the next few years.

5. Review of Member Materials for Integrated Plans
    a. Historically, MMCO has partnered with and supported states that require D-SNPs to use integrated member materials – a single set of member materials that describe both the Medicare and Medicaid benefits covered by the D-SNP (and its affiliated Medicaid plan, if applicable). These integrated member materials support two of MMCO's key goals: simplifying the process for dually eligible individuals to access the items and services to which they are entitled under the Medicare and Medicaid programs, and increasing dually eligible individuals' understanding of and satisfaction with their coverage. [4]

       MMCO provides guidelines and timelines that support states' successful member material development. Early and frequent communication with MMCO helps states to proactively address policy considerations and ensure materials are tailored to states' unique requirements. MMCO also works with health plans and other stakeholders to review and adjust member materials before they are finalized.

       Typically, MMCO releases model member materials for AIPs in May or June of each year. These model materials are an integral part of the member material development process, and releasing these materials in May/June allows sufficient time for health plans and states to meet their deadlines for the upcoming performance year. Member materials must be finalized by mid-October each year, with material review occurring between June and October. These member material reviews are especially important in light of new requirements for integrated ID cards and Health Risk Assessments (HRAs) finalized in the recent CY2026 Medicare Advantage and Part D Final Rule.

6. Closure of Regional Offices: Impact on Resources and Partnerships
    a. The recent reorganization at HHS also included the closure of six regional CMS offices. These offices were integral resources for states and health plans that were establishing and maintaining integrated care programs. Under HHS' new structure, it is not clear how states and health plans will receive this support and technical assistance moving forward.

[4] Integrating Dual Eligible Special Needs Plan Materials to Promote Enrollee Understanding of and Access to Benefits | ICRC

National
MLTSS
Health Plan Association

Originally charged in statute to break down silos between Medicare and Medicaid—both at the federal and state level—MMCO has been incredibly effective at engaging with different CMS offices, states, and private health plans to close gaps between these two programs and reduce program inefficiencies. As the federal leader in policy reform for dually eligible individuals, MMCO drives nationwide efforts to enhance care quality, improve outcomes, and increase cost-effectiveness for these individuals. The MLTSS Association recognizes the importance of MMCO's role in advancing integrated care and we want to ensure that the vital functions of this office will continue after the recent restructuring. We would welcome the opportunity to meet with CMS to discuss these questions further and are happy to provide any support during this period of transition.

Sincerely,

Mary Kaschak
Chief Executive Officer