

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 7, 2022

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov

Re: CMS-4192-P Medicare Program: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Notice of Proposed Rulemaking (NPRM).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations who have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Our comments are keyed to the headings in the NPRM and are presented in the order discussed there.

A. Improving Experiences for Dually Eligible Individual

General Comment

Justice in Aging is supportive of the direction of CMS's proposals with respect to D-SNP regulations. We appreciate that the agency has sought to tighten and clarify requirements and that it has throughout focused on beneficiary experience and beneficiary needs. We particularly note the extent to which CMS dug into the data to develop a picture of what is happening on the ground in different states. Including that detailed information in the NPRM was very helpful for stakeholders in understanding the current situation and in developing informed responses to the proposals.

Our comments primarily explore areas where we believe that CMS could include further specificity in the regulations. We note, for example, that there are several instances where CMS indicated a desire not to be overly prescriptive and others where it proposes to apply certain requirements only on a narrow category of D-SNPs. While we appreciate the agency's caution, we also note that D-SNPs are growing at an explosive rate and, in contrast, the process of proposing and adopting regulations is of necessity a slow one. We ask CMS to balance its caution against the need to ensure that the regulatory

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

framework keeps up with D-SNP growth and is sufficiently detailed and robust to protect the over four million dual eligible individuals in D-SNPs and those expected to join as the D-SNP landscape expands.

Ombuds Program

Before discussing provisions that are in the NPRM, we note one provision that is not, specifically an ombuds program. One of the major successes of the Financial Alignment Initiative (FAI) was the use of an ombuds program to assist individuals in navigating Medicare-Medicaid Plans (MMPs). Ombuds programs had multiple successes in identifying systemic issues. In our experience, we saw that they were often able to resolve issues that otherwise might have required lengthy appeals. The relationships that ombuds built with state agencies, CMS, and plans brought value to all parties and significantly helped to improve program operation. The value of an ombuds program for beneficiaries in D-SNPs would be the same or greater.

We recognize that state Medicaid programs have ombuds, but it is important that there be ombuds staff who are specifically dedicated to the complex issues that people dually eligible for Medicare and Medicaid face and well-versed in benefits and rights in both programs. The FAI provided dedicated funding for ombuds and we believe it was money well spent. We urge CMS to require and fund ombuds programs to serve individuals enrolled in D-SNPs.

3. Enrollee Participation in Plan Governance (§ 422.107)

We share CMS's view that enrollee advisory committees have played an important role in MMPs and should be required for all D-SNPs. We agree that the current requirements regarding representative membership and minimum areas where advice should be solicited are important and appropriate. We also appreciate and believe that it is very important that review of compliance with this requirement would be part of the audit procedure.

Although we appreciate that regulations, particularly those imposing new requirements, should not be overly prescriptive, we have concerns that, even at the initial stage, this regulation needs to be tightened in order to be effective. We also strongly urge CMS to issue additional sub-regulatory guidance concerning its expectations of plans. Recognizing that developing robust advisory committees is challenging, we also urge CMS to provide technical assistance to plans.

We have several specific concerns where we believe amending the proposed text of the regulation is essential:

Combined Participant Advisory Committees: We believe that blanket permission for plan sponsors to establish a single Advisory Committee for an entire state would so dilute the value of the Committees in many states to make them of little value. We note, for example, the situation in California where the state is proposing to use D-SNPs statewide as a primary vehicle for integrating care for dual eligible individuals. Having a single Advisory Committee representing enrollees in a plan in densely populated urban Los Angeles County with a highly diverse group of enrollees, in a plan in the rugged rural, mostly white, Shasta County, and in a plan serving the primarily Latino farming communities of the Central

Valley would dilute the voices of all enrollees and provide little actionable information for plans. Yet, we have concerns that, in the interests of economy, plan sponsors would choose to do the minimum required by the regulation.

We propose instead that the default under the regulation should be a requirement that each separate D-SNP must establish a Committee drawn from consumers within its service area, with CMS permitting consolidation of Committees where plans make a showing that a consolidated Committee serves the purposes of the regulation. We recognize that, in some situations, consolidating Advisory Committees for plans serving adjacent communities or sparsely populated areas could be reasonable and practical. Allowing plans to choose statewide Committees without restrictions, however, would eviscerate the value of the regulation and effectively silence the voices of enrollees.

Frequency of meetings: Without some minimum meeting frequency, we fear plans would opt for annual meetings, which would have limited value. We ask that CMS, at a minimum, require at least semi-annual meetings.

Implementation Councils: In addition to Consumer Advisory Committees for each plan, we also urge that CMS establish and support consumer-driven councils at the state level similar to the highly successful model developed in the Massachusetts Financial Alignment Initiative. The role of an Implementation Council would be distinct from Consumer Advisory Committees, which focus on specific issues with specific plans. An Implementation Council addresses systemic issues across plans, its work is more intensive than that of Consumer Advisory Committees, and its interactions with state Medicaid agencies is more sustained. It can play an important role in ensuring accountability and transparency. An implementation Council can work effectively in tandem with Advisory Committees, enhancing their value by elevating common concerns, as well as providing education and support to consumers serving on plan-level Committees. Similarly, the Massachusetts experience demonstrated strong synergies between the work of the Implementation Council and the FAI ombuds. The value of an Implementation Council is one of the most exciting learnings to come out of the FAI and we strongly urge CMS to incorporate the model as it designs D-SNP oversight and governance mechanisms.

4. Standardized Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments (422.101)

We strongly support inclusion of these standardized questions in all health risk assessments (HRAs). We recognize that inclusion of questions about social determinants of health is an iterative process, as are ongoing efforts to standardize other portions of the HRA, and we ask that CMS continue to work to do more in this area.

With respect to the three areas included in the current proposal, beyond the obvious importance of housing instability and food insecurity, we agree with CMS that problems with access to transportation can seriously impact access to care. Advocates and beneficiaries report that these problems are

widespread.¹ NEMT challenges also are problems susceptible to achievable solutions and deserve attention.

We ask that CMS require that HRAs collect demographic information including race, ethnicity, sex, gender, gender identity, sexual orientation, language, and disability and that the information be recorded and stored so that it can be sorted both by particular category and intersectionally. It is important to have data that identifies disparities both within a plan and in the D-SNP population more broadly. This information also is a necessary element for comparing provider access, distribution of supplemental services and outcomes so that inequities can be identified and addressed.

In addition to identifying individuals needing assistance with housing, food or transportation, plans also need to take steps to address those needs, either through their own programs or through meaningful assistance in linking members to other resources in the community. We urge CMS to establish oversight mechanisms and standards to ensure that plans have systems in place to provide that assistance.

5. Refining Definitions for Fully Integrated and Highly Integrated D-SNPs

a. Exclusively aligning FIDE SNPs

We support the proposal to require that FIDE SNP membership be exclusively aligned. Beneficiaries in FIDE SNPs who receive their Medicaid services either through fee for service or, even of more concern, a misaligned Medicaid MCO, would necessarily be outliers in the highly integrated FIDE SNP model. The FIDE SNP model simply is not designed to address their needs. They would get little benefit from being in a FIDE SNP. Moreover, including them in a FIDE SNP diverts plan resources and significantly complicates beneficiary notices, appeals procedures, and other key elements of the beneficiary experience.

We ask, however, that if CMS adopts the proposed regulation requiring exclusive alignment, it take care to ensure that unaligned individuals in Pennsylvania, Arizona, and Virginia FIDE SNPs be protected if those plans transition to exclusive alignment. They will need notices and counseling about the impact of the change, particularly its impact on access to their Medicaid providers, and on their options. Further, these individuals may need access to continuity of care protections, particularly with respect to Medicaid providers and services.

Further, we ask that CMS also consider requiring exclusively aligned enrollment for HIDE SNPs. All the rationale for exclusive alignment with FIDE SNPs applies to HIDE SNPs as well. In addition, we believe that exclusive alignment also is the most rational approach in all states that require their dual eligible beneficiaries to be in MCOs. Even if a D-SNP does not qualify as a HIDE SNP or FIDE SNP, misaligned enrollment in an MCO operated by a different sponsor offers little value and significant potential downside for D-SNP members.

¹ See, e.g., Justice in Aging and Center for Consumer Engagement in Health Innovation, “Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults,” (Oct. 2016), available at <http://justiceinaging.org/wp-content/uploads/2016/11/NEMT-Medicaid-Transportation.pdf>.

b. Capitation for Medicare Cost Sharing for FIDE SNPs and Solicitation of Comments for Applying to other D-SNPs

We fully agree with CMS that providers serving dual eligible individuals in D-SNPs should not be burdened with complex procedures for payment of co-insurance and deductibles. Policies that make collecting payment for serving dual eligibles harder or diminish the amount of compensation available act as a deterrent to joining provider networks that serve these individuals, limiting access to care.

We also strongly support the proposal that, for FIDE SNPs, improper billing protection and provider reimbursement would apply to all dual eligible plan members, not just QMBs. It is our experience that many if not most dual eligibles do not know whether they are QMBs and providers also find the distinction confusing. Especially with the limited amounts that states actually cover because of widespread adoption of the “lesser of” policy, eliminating this administrative complexity weighs heavily in favor of the proposed rule.

Although we strongly support simplification, we have questions about how this rule would interact with negotiated payment agreements between plans and providers.

The process appears relatively straightforward with providers receiving from the plan the basic Medicare rate, which would then be augmented by the co-insurance based on the state’s payment schedule and its policies with respect to the “lesser of” payment option. Our questions arise primarily about other situations. They include:

- Proposed § 422.2(2)(i) provides for coverage of “Primary care and acute care, including Medicare cost sharing . . .” The placement of the cost sharing language under primary and acute care appears to limit the provision to covering only those two categories of services and exclude providers and suppliers of other services, e.g., pharmacists providing Part B drugs, DME suppliers, etc. If that is not the intent, we propose modifying the regulation to avoid ambiguity. If the exclusion is intentional, we question why other providers and suppliers should be excluded.
- For those dual eligible members of a FIDE SNP who are not QMBs, is it correct that the provision of co-insurance would be the financial obligation of the plan and not included in the calculation of the capitated co-insurance payment that the state would make to the plan?
- We have questions about how the state coverage of co-insurance plays out in situations where plans make alternate payment arrangements with providers, for example, capitated per patient per month payments, quality bonuses and the like. We have similar questions about how this provision works with a network, such as Kaiser, with salaried providers and facilities directly owned by the plan.
- There also is a broader disconnect with negotiated provider rates more generally, even when not capitated. Our concern is how to determine if the state capitated payment to the plans actually achieves the purpose of improving provider access for dual eligible individuals in D-SNPs. Given the latitude and autonomy that plans have in negotiating provider rates, and the lack of transparency, monitoring implementation appears to be a challenge.

In light of these concerns, we ask CMS to move carefully in implementing this proposal and engage in sufficient information collection to understand how plans are distributing the state funds.

c. Scope of Services Covered by FIDE SNPs

As a preliminary comment to both subsections (c) and (d), we support CMS's approach of tightening and clarifying standards for designation of FIDE SNPs and HIDE SNPs. We recognize that, in some cases, the way a state Medicaid program has evolved may make these highly integrated options a poor fit. Instead, CMS can explore with those states other ways of improving coordination of Medicare and Medicaid benefits. There are many ways short of HIDE SNPs and FIDE SNPs to improve integration of services.

NEMT: We have some concerns about excluding Medicaid NEMT from the services that must be included in a FIDE SNP's contract with a state. We recognize that many states currently have statewide contracts with NEMT providers that would complicate a requirement to move NEMT coverage into FIDE SNPs. However, the NEMT benefit in many states does not work well for beneficiaries and coordination with doctors and other service providers has been poor.² Integrating NEMT, if done well, should be able to help address some of those current deficiencies. We also note that use of NEMT is disproportionately high among dialysis patients, and others with serious chronic conditions, all individuals who most need coordination among providers, including NEMT providers.³

Home Health and Durable Medical Equipment: Our particular concerns in this section are around durable medical equipment (DME). Beneficiaries have a difficult time navigating between Medicare and Medicaid for coverage of complex DME and for repair of items that may be covered by one program or the other. It is especially important that DME be fully integrated in FIDE SNPs. Since all existing FIDE SNPs already cover Medicaid home health services and DME, we question whether waiting until 2025 is necessary to adopt this requirement for new FIDE SNPs.

Behavioral Health Services: We appreciate that, since behavioral health is a core Medicaid service for the dual eligible population, its inclusion should be required for FIDE SNPs.

We raise the caution, however, that CMS should require strong steps to avoid disruption in behavioral health care when transitioning individuals in the 24 FIDE SNPs that do not now incorporate behavioral health in their contracts. Consistency, continuity, and ongoing access to trusted providers are essential elements in behavioral health, and even small disruptions in provider networks or changes in procedures to access providers can set back progress for affected beneficiaries.

Further, whenever approving carve-ins of behavioral health in any D-SNP, it is also important to ensure that the move does not degrade the quality of care. For example, some county systems have experience in behavioral health for persons with serious mental illness that is difficult to duplicate. In some jurisdictions, carved-out behavioral service systems, which serve many individuals who are homeless or in danger of homelessness, are closely integrated with housing service providers, working together to

² See, e.g., R. Grapevine, [Left Behind: Medicaid Patients Say Rides to Doctors Don't Always Come](https://www.khn.org/news/medicaid/2022/01/12/medicaid-patients-say-rides-to-doctors-dont-always-come) | Kaiser Health News (khn.org) (Jan.12, 2022).

³ See [Chapter 5 Mandated Report on Non-Emergency Medical Transportation](https://www.macpac.gov/reports/2021/06/01/chapter-5-mandated-report-on-non-emergency-medical-transportation/) (macpac.gov) (June, 2021), p. 166 .

bring stability to this high need population. In the states where behavioral services were integrated into the financial alignment demonstrations, the path was often rocky, particularly where plan sponsors had little experience in the area.⁴

e. Medicaid carve-outs and FIDE SNPs and HIDE SNPs

We appreciate the clarification of CMS policies regarding FIDE SNP and HIDE SNP designation. In thinking about the treatment of particular carve-outs and carve-ins, CMS and states must always prioritize the impact on beneficiaries. We agree with CMS, for example, that when in-home personal care services are carved out, a plan should not be designated as a FIDE SNP. Having said that, however, does not mean that we would support pressure, either by FIDE SNP designation or otherwise, to rush to dismantle effective programs that work well solely for the purpose of having an integrated model.

We have similar concerns with respect to behavioral health services. It is important not to disrupt effective behavioral health models solely so that integration can be achieved.

There are many ways to achieve more care coordination short of full integration into a FIDE SNP or HIDE SNP. We have seen, for example, value when county personnel from IHSS, California's carved-out personal care program, participated in care planning meetings in the FAI.

f. Service area overlap between FIDE SNPs and HIDE SNPs and Companion Medicaid plans.

If a plan is accorded HIDE SNP, it should offer HIDE SNP benefits to all its members. The fact that nearly 100,000 HIDE SNP members do not have access to a matching MCO is shocking and entirely contrary to HIDE SNP designation. We strongly support CMS's proposal to close this loophole. We do not support the alternatives discussed in the NPRM. Whenever any subset of enrollees needs to negotiate a different path from others, it causes confusion among enrollees, providers, and plan staff and limits opportunities for integrated notices and appeals.

6. Additional Opportunities for Integration through State Medicaid Agency Contracts (§ 422.107)

a. Limiting Certain MA Contracts to D-SNPs

We strongly support separate contracts for D-SNPs and urge CMS to require separate contracts for all D-SNPs, not just the narrow optional set in the proposed regulation. If CMS limits itself to the current proposal, we ask that the agency use the process as a template for a wider required, not optional, separation of D-SNP contracts in the future.

Although D-SNPs have operated for 15 years, their track record in serving dual eligibles has been largely disappointing. In our view, one contributing factor has been the failure to measure their performance

⁴ See, "The Coordination of Behavioral Health Care Through Cal MediConnect," (Aug 2017) available at http://www.thescanfoundation.org/sites/default/files/coordination_of_behavioral_health_care_through_cal_mediconnect_brief_ucb-august_2017.pdf/

separately, making it difficult to hold them accountable for their performance in serving the unique needs of dual eligible enrollees.

CMS has asked about any special concerns if the agency established a cross-walk enrollment when a D-SNP moves to a separate contract. One possible concern would be whether a change would require a new member card or changes in bill routing by providers. It would be important to avoid such changes to minimize disruption in services.

b. Integrated Member Materials

We strongly support use of integrated member materials for all plans with exclusively aligned enrollment. Individuals navigating their Medicare and Medicaid benefits need as much simplicity and clarity as possible and we urge CMS to work with states to include as many key documents as feasible.

We particularly urge the inclusion of the ANOC in the initial set of integrated documents. Though the summary of benefits and the provider and formulary lists are very important reference documents for enrollees to use throughout the plan year, the ANOC serves a different function. It is the notice that provides the critical information about the changes that beneficiaries need to consider during the Open Enrollment Period. It also is a relatively short notice and is most likely to be read by the beneficiary when it is received. The ANOC empowers dual eligible individuals to make decisions about their coverage and it also helps to prevent surprises--and disruptions--because of unanticipated changes in coverage or providers. Enrollees often expect that everything in their plan will be the same from year to year. A single document that lays out the changes on both the Medicare and Medicaid side is the simplest and most effective way to alert them to the differences that they should expect. In our view, an integrated ANOC is essential and should be prioritized.

We also urge that the production schedule for integrated notices provide adequate time for use of focus groups to ensure that information is communicated effectively and meets the real needs of beneficiaries. CMS has indicated that such groups have been very helpful in the past. Continued testing can lead to further improvements. We also ask that focus groups consist of a diverse group of beneficiaries representative of each plan's demographic mix.

We ask that CMS explicitly include in the regulation a requirement that integrated materials must comply with state translation standards if those standards are more favorable to the beneficiary than current Medicare Advantage requirements. The NPRM at p. 1872 makes mention of scheduling time for translating integrated communications into a language that is the primary language of 5% of the service area, which is the Medicare translation threshold. To require only meeting the Medicare standard would mean that, in some states, many individuals with limited English proficiency would be worse off getting integrated materials, a result that is contrary to the goal of the regulation. With unintegrated materials, they would at least receive communications about their Medicaid benefits in a language they could understand. The three-way contracts in the FAI explicitly required that all integrated enrollee communications be translated into the languages required by the state Medicaid program or the Medicare program, whichever standard is more favorable to the enrollee. We urge that these regulations do the same.

We also ask that CMS consider applying a most-favorable-to-the-beneficiary translation requirement to all D-SNPs, including those that are unintegrated and/or do not have aligned enrollment. All D-SNPs, with the exception those that only enroll partial duals, enroll individuals who are receiving information about their Medicaid benefits under state translation rules. If D-SNPs are not providing their members with information about their Medicare benefits in the same language, a very basic opportunity to improve the beneficiary experience and make it more integrated is lost. There is nothing integrated, for example, about a Chinese speaker receiving notices about Medicare benefits in English and notices from the same plan sponsor or another MCO or Medicaid providers about Medicaid benefits in Chinese. Plan sponsors choosing to enter the D-SNP market should at least be held to this minimal level of integration with Medicaid standards.

c. Joint State/CMS Oversight

State Access to the Health Plan Management System: We support state access to HPMS. The FAI has shown that successful management and oversight of integrated plans requires active participation by both CMS and states. Since states, through SMACs, have a major role in setting the obligations of D-SNPs and monitoring their performance, it is important that they have access to HPMS information. We also note more generally that it is the experience of advocates that limitations and technical barriers to information exchange between states and CMS/SSA on dual eligibles, both with respect to individuals and programs, have created many barriers to smooth operation of programs affecting dual eligibles. At the individual level, these technical issues have been a significant cause of disruptions in coverage and care. We appreciate the attention that CMS, particularly MMCO, has focused on improvements in this area and urge continued efforts to address both the policy and operational concerns.

State-CMS Coordination on Program Audits: We strongly support coordination in audits between states and CMS. Audits are a central element in oversight of plans and the statutory regime for D-SNPs requires and depends on federal and state coordination.

State Input on Provider Network Exceptions: We support this proposal. Full state and federal cooperation and participation on oversight of D-SNPs is important to the success of the D-SNP model. We note that advocates and beneficiaries tell us that a primary reason for individuals choosing to disenroll from D-SNPs and FAI plans has been narrow networks that enrollees found restricted them from accessing providers whom they considered important for their care.

We also ask that CMS and states be particularly attentive to the impact of any exceptions on availability of providers with offices that are accessible to persons with disabilities, as well as availability of providers serving particular language or cultural communities.

d. Comment Solicitation on Financing Issues

We support MLR regulations that facilitate improved services to beneficiaries across the two programs. Much of the discussion in this section is about how Medicare supplemental services could reduce Medicaid costs. Our understanding, however, has been that the major cost savings have been in the other direction, that is, that Medicaid HCBS outlays resulted in lower Medicare costs for medical services. We appreciate and support more exploration on how, in both directions, MLR calculations can

facilitate improved services and improved outcomes for dual eligible individuals, particularly in HIDE SNPs and FIDE SNPs. The combined payment stream in the FAI demonstrations was a key alignment element which is lost with D-SNP rules. Aligning MLR provisions could be helpful in incentivizing plans to use the full arsenal of services to improve beneficiary health.

More generally, however, we have concerns about the tenor of the discussion on page 1877 of the NPRM, which talks about supplemental benefits “replacing costs that would otherwise be a Medicaid responsibility.” Our concern is that supplemental benefits are, by their nature “supplemental.” In any given year, a plan can choose to offer them or not offer them. Plans have the discretion to determine the criteria for coverage. In contrast, Medicaid (and Medicare Part A and Part B) benefits are entitlements upon which beneficiaries can rely, with eligibility criteria set by state and federal agencies, and often by statute. We fear that the expansion of supplemental benefits can easily become an excuse for state Medicaid programs to fail to offer the robust services that Medicaid beneficiaries need. For example, if D-SNPs decide to offer additional personal care hours or stronger dental benefits because a state’s current Medicaid program coverage is inadequate to meet plan member needs, there is little incentive for states to make their Medicaid benefit package sufficiently robust.

This approach to supplemental benefits for dual eligibles also makes Medicare freedom of choice increasingly illusory. If the only way a dual eligible individual can access such core health needs as adequate dental coverage or enough personal care hours to live safely in the community, that individual really does not have the choice to switch to Original Medicare, even if for reasons of network adequacy or other problems, the individual wants to move to Original Medicare.

We recognize that currently getting needed health services through supplemental benefits is better than not getting them at all and we also recognize that coverage expansion requires legislative action at the state and federal level and is beyond the power of CMS. Nevertheless, as CMS continues to build the regulatory and payment framework around D-SNPs, we urge the agency to do so in a way that does not encourage or reward leaving core needs to the option of plan sponsors, rather than fully within regular benefit programs, which have stability and consumer protections that are not available with supplemental services. Over the longer run, supplemental services should be genuinely supplemental, addressing social determinants of health, not basic needs, and we ask that as CMS keep this goal in mind as it moves forward.

7. Definition of Applicable Integrated Plan Subject to Unified Appeals and Grievances Procedures (§ 422.561)

We agree with CMS that fully aligned enrollment, rather than strict compliance with the definitions of HIDE SNPs or FIDE SNPs, is the best determinant for requiring plans to provide unified appeals and grievance procedures. There are numerous states that, because of the historical development of their Medicaid programs, have significant carve-outs of Medicaid services and are likely to maintain those carve-outs for some time. That fact should not deprive dual eligible D-SNP members in aligned plans of the significant benefits of integrated grievance and appeals systems for other services. We note particularly that the benefit coverage criteria for affected plans are, in fact, the areas where overlap is most common, including specifically DME and home health.

We also ask CMS to consider, either in this rulemaking or in the future, expanding unified appeals to aligned plans that may not meet the current narrow definition of exclusive alignment. State policies regarding population carve-outs and FFS opt-outs on the Medicaid side vary greatly. We can envision situations where a D-SNP has 80 or 90 percent aligned enrollment with the remainder in FFS Medicaid. We believe that the benefits to the majority of plan members of a unified appeal system in those D-SNPs would far outweigh the relatively small burden on the D-SNP of separate notices and processes for their Medicaid fee for service members.

8. Permitting MA Organizations with Section 1876 Cost Contract Plans To Offer Dual Eligible Special Needs Plans (D–SNPs) in the Same Service Area (§ 422.503(b)(5))

This provision appears to address a specific situation in one state. The agency has proposed to closely monitor enrollment after adoption of the proposed regulation and we encourage the agency to do so.

9. Requirements to Unify Appeals and Grievances for Applicable Integrated Plans (§§ 422.629, 422.631, 422.633, and 422.634)

We appreciate and support the clarifications and changes that CMS proposes with respect to unified appeals and grievances. Having unified appeals is an important improvement in the experience of dual eligible individuals. And, because appeal rights are a fundamental beneficiary protection, it is valuable and appropriate that core appeal procedures be incorporated into regulation and not relegated to sub-regulatory guidance.

We propose an additional clarifying amendment to the current appeal regulations. Because provider input is an essential part of an appeal, we urge that the assistance owed by a plan to enrollees should explicitly encompass assistance to the enrollee’s provider, if requested. We ask therefore that CMS amend § 422.629(e) as follows:

(e) **Assistance.** In addition to the requirements in [§ 422.562\(a\)\(5\)](#), the applicable integrated plan must provide an enrollee *and, upon request, an enrollee’s provider(s)*, reasonable assistance in completing forms and taking other procedural steps related to integrated grievances and integrated appeals.

We note that § 422.696(j) already requires that information on appeals procedures be given to providers when they contract with the plan. While this is useful, it is not a substitute for assistance at the point when the provider is actually participating in an appeal or grievance.

11. Compliance with Notification Requirements for D–SNPs that Exclusively Serve Partial-Benefit Dually Eligible Beneficiaries (§ 422.107(d))

We appreciate and support this proposal. We note that, since it is not uncommon for partial dual eligible individuals to experience a change in circumstances making them eligible for full Medicaid benefit, the requirement that a plan sponsor also operate a D-SNP serving full-benefit dual eligible individuals could be helpful for care continuity in a transition.

We have continuing concerns, however, about enrollment of partial dual eligible individuals in D-SNPs more generally. Although we have heard some anecdotal assertions that the supplemental benefits

offered by some D-SNPs can be attractive to partial duals because they tend to be more relevant to low income individuals, we have not seen data or specific analysis providing any insight into whether that actually is the case. If CMS continues to allow D-SNPs to enroll partial duals, then it is incumbent on the agency to undertake such an analysis and establish minimum criteria to ensure that D-SNPs have relevance and value to partial duals.

12. Attainment of the Maximum Out-of-Pocket (MOOP) Limit (§§ 422.100 and 422.101)

Justice in Aging supports CMS’s proposal to revise the regulations governing the maximum out-of-pocket (MOOP) limits for Medicare Advantage plans to require that all costs for Medicare Parts A and B services accrued under the plan benefit package, including cost-sharing paid by any applicable secondary or supplemental insurance or any cost sharing that remains unpaid, is counted towards the MOOP limit.

Under the current MOOP method of counting, the catastrophic category is never reached for most D-SNP enrollees, with the result that state Medicaid program liability for co-insurance for QMBs is never met and plans never are obliged to cover costs at the catastrophic rate. This result distorts the statutory design. It is a windfall for D-SNPs compared to other Medicare Advantage plans and an unfair burden on state Medicaid budgets.

The proposed regulation would correct this situation by counting Medicaid cost-sharing, including amounts unpaid because of “lesser of” state payment policies, in calculation of MOOP. Justice in Aging supports the proposal as a reasonable approach that puts D-SNPs on the same footing as other Medicare Advantage plans.

13. Comment Solicitation on Coordination of Medicaid and MA Supplemental Benefits

Clarifying availability of supplemental benefits: A persistent issue we see with supplemental benefits is confusion by D-SNP members about what benefits are available to them, what limitations exist on access to the benefits and what their appeal rights are with respect to those benefits. Individuals need clear information both to make informed enrollment decisions and, once enrolled, to understand their rights to access particular services. Confusion about whether a benefit is really “extra” or is something already covered by Medicaid or Medicare is one concern. More specificity in § 422.102 as well as in marketing rules and state contracts would be helpful in this regard.

Using Model of Care to Coordinate Medicaid Services: We are pleased to see that CMS is proposing to bring the Model of Care more directly into state contracting. We hope this is part of a bigger effort to more explicitly incorporate the Model of Care process into the regulatory and contractual oversight regime and to make the entire Model of Care process more transparent to stakeholders.

We have been told by CMS that the process of developing a Model of Care and obtaining approval is quite rigorous, as reflected in the NCQA [webpage on Models of Care](#). Further, we understand that when the stated goals of the Model of Care are not met, plans are required to take actions to address the gap.

To external stakeholders, however, it appears that the Model of Care process runs on separate—and largely invisible—tracks from the rest of the D-SNP regulatory regime. We have scoured the internet and cannot find any Models of Care on any government or plan website (a couple of years ago, the NCQA

site included three “summaries” of MOCs but they have since been taken down). The NCQA website shows MOC scores for plans but nothing else about the plan’s model. We are unclear about how and whether successes and deficiencies in Models of Care play a role in plan evaluations, star ratings, etc. External stakeholders have had no input into the development of Models of Care. We have seen no cross-plan evaluation of the process either by NCQA, CMS or external parties.

Advocates are interested in learning more about Models of Care and in having an opportunity to explore these issues more fully with CMS. We are particularly interested in learning more about CMS’s invitation in the NPRM to states to impose additional requirements for a D-SNP’s Model of Care.

Data collection on supplemental benefits: Though not discussed in the NPRM, we want to emphasize to CMS the importance of collecting data on the delivery and use of supplemental benefits in D-SNPs. Currently, though we know what supplemental benefits are being offered by D-SNPs, we do not know how many people are receiving them. We also do not know who these people are, an important issue when addressing disparities. We urge CMS to collect data on delivery of supplemental benefits by race, ethnicity, sex, gender, gender identity, sexual orientation, language, and disability.

Network adequacy for supplemental benefits: As we noted below in our comments on network adequacy in Medicare Advantage more generally, we urge CMS to be thinking about standards and monitoring for network adequacy for supplemental benefits. This is particularly important for D-SNPs where a state may include a requirement for specific supplemental benefits in its contract with a D-SNP. One concern with supplemental benefits is that network inadequacies can be masked. For example, if a D-SNP offers personal care services beyond Medicaid levels, but network providers and care coordinators are aware that there is a shortage of personal care service providers available to the plan, they may be reluctant to prescribe additional services beyond the Medicaid levels and, in most cases, the plan member would not even be aware that more should have been offered.

14. Converting MMPs to Integrated D-SNPs

Justice in Aging does not support the proposal of CMS to shut down the FAI and convert existing MMPs to D-SNPs. While we recognize that some states, including California, the largest state in the demonstration, have chosen to move from MMPs to D-SNPs, we do not believe it would be good policy for CMS to take steps that would essentially force this decision on all remaining states in the demonstration.

The flexibilities available in the FAI, particularly the single payment stream and opportunity for shared saving by Medicare and Medicaid are key to full integration of services. Those simply are not available in the D-SNP model, even with the improvements proposed in the NPRM.

We also believe that continuing to support the demonstrations is fully consistent with the agency’s work to develop the D-SNP model. D-SNPs provide a path to integration that accommodates states at various stages. Having fully integrated FAI models that continue to improve and evolve will be helpful in the evolution of D-SNPs.

Most importantly, beneficiaries in successful FAI plans would be forced to move into models that are less integrated than those in which they are now enrolled. As CMS notes, the transitions themselves, as

with any care transitions, also are likely to present significant challenges. The reasons behind the proposal to move 400,000 individuals into something less than what they now have are primarily administrative. While we recognize that it is easier to administer one program rather than two, we believe that the benefit to FAI plan members and the opportunities for additional learning outweigh administrative concerns. Once dismantled, FAI plans cannot be resurrected. We recognize that CMS cannot force states to continue in the FAI if they choose another path, but we believe that, for those states that wish to remain in the FAI, CMS should continue to offer its full support.

B. Special Requirements During a Disaster or Emergency (§ 422.100(m))

We appreciate the CMS is attempting to provide more clarity to plans about their requirements during an emergency. We also recognize that the agency's intent is that plans should interpret their obligations broadly.

We have concerns, however, about the proposed definition in § 422.100(m)(6) defining "disruption of access to health care" as an "interruption or interference throughout the service area." Some Medicare Advantage plans serve a wide service area. For example, the Inland Empire Health Plan, currently operating as a Medicare-Medicaid Plan, serves San Bernardino and Riverside Counties, a 27,000 square mile area encompassing significant urban centers, desert, mountain and farm communities, and even tribal lands.

It is very possible that a severe interruption—a wildfire, earthquake or severe weather event, for example-- could have disastrous impact on one portion of a plan's service area while other portions are unaffected. We ask that the definition take this into account and that the regulation be clear that the special requirements for disasters and emergencies would apply to those individuals in an affected area, even if the event does not affect the entire service area of the plan. Individuals in hard-hit communities should not have to seek individualized exceptions to in-network requirements when they are struggling with many other urgent needs.

We also note that CMS plans to issue sub-regulatory guidance to plans with more detailed guidance. We ask that the guidance particularly address the needs of individuals who are required to evacuate from a disaster area, particularly those whose homes are damaged or destroyed in the disaster. Even after services are restored to the affected area, they may still be living outside the service area, dealing with uncertainty while awaiting information on the habitability of their home, insurance availability and other matters. We ask that CMS provide plans with detailed guidance on how to address these situations in ways that minimize disruptions in care.

C. Amend MA Network Adequacy Rules by Requiring a Compliant Network at Application (§ 422.116)

We support the CMS proposal that Medicare Advantage plans must demonstrate rather than attest that they meet network adequacy standards. We also ask CMS to reinstate network adequacy requirements that were weakened. We ask specifically that CMS reverse permission for plans to count telehealth-only providers toward network adequacy and reestablish the minimum percentage of enrollees that must

reside within the maximum time and distance standards in non-urban counties at 90 percent rather than 85 percent.

We ask CMS to closely monitor the actual availability of network providers, including through secret shopper surveys. In addition, we urge CMS to begin to look at networks more closely from an equity and disparities perspective and start considering benchmarks or at least guidelines for plans on issues like disability access among providers, providers that can offer services in non-English languages, providers in low income neighborhoods, etc.

We also want to raise a general comment on the importance of network adequacy. In our work with on-the-ground advocates, when we hear of individuals wishing to drop their Medicare Advantage plan, it most frequently happens when they experience a significant change in health status and they believe that the plan's network is not meeting their needs. Thus, at a time when they might benefit most from the care coordination services that a Medicare Advantage plan should be providing, they are dropping out. Though plans do not discourage high cost individuals from enrolling at the start, there is a negative selection at the back end when inadequacies and limitations incentivize individual to leave right at the point when they become the most expensive to serve. We urge CMS to ensure that its network adequacy standards do not encourage this result and that its oversight is sufficiently rigorous to make sure that its standards are being followed.

Finally, network adequacy for supplemental benefits is relatively uncharted territory, but important. If plans are offering supplemental benefits like dental services or personal care services, it is important that those services be fully staffed and that beneficiaries can access them without significant wait times or long travel. There needs to be some standards and monitoring of the availability of these networks.

F. Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees (§§ 422.2267(e) and 423.2267(e))

3. Multi-Language Inserts

We strongly support the proposal to reinstate the requirement for plans to include a multi-language insert in vital documents in the top 15 most common non-English languages in the United States. Use of inserts is a small but important step in addressing disparities in access to the Medicare program's benefits and in achieving compliance with the mandates of Section 1557 of the Affordable Care Act.

To address health disparities, it is critically important that individuals get information about their benefits and assistance with their health needs in a language that they understand and in which they are comfortable. More than one in ten individuals 65 or older speaks a language other than English at home, and the percentages are even higher among individuals with low incomes. Yet use of language services on plan help lines and at 1-800-MEDICARE is low. Many individuals are unaware of their right to language assistance; others are reluctant to ask. Successfully reaching beneficiaries with limited proficiency in English requires not only that language assistance be available but also that the invitation to use such assistance be prominent and sustained. Reinstatement of the inserts is a step in that direction.

4. Third Party Marketing Organizations

We support the proposal to strengthen oversight of third-party marketing organizations (TPMOs), including the requirement of disclaimers informing individuals that such organizations do not sell every plan available in a given area. We also urge CMS to roll back recent changes to marketing guidelines that weakened consumer protections, including blurring the distinction between marketing and educational events.

We urge vigorous enforcement of the proposed regulations. Choosing one's health care plan is serious business and qualitatively different from choosing a gadget or a non-stick fry pan from a TV ad. We appreciate this start in reining in current abuses but ask CMS to consider more expansive measures to ensure that the marketing permitted for Medicare-contracted health and drug plans is consistent with the importance of the choices consumers are asked to make.

Conclusion

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact Georgia Burke at gburke@justiceinaging.org.

Sincerely,



Amber Cutler
Directing Attorney