

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 31, 2022

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4203-NC

Submitted electronically via [regulations.gov](https://www.regulations.gov)

## **Re: Medicare Program—Request for Information on Medicare Advantage. CMS-4203-NC**

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Request for Information (RFI).

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 enrollees and populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Given our focus on the impact of health care programs on low income older adults, our comments primarily address the impact of the Medicare Advantage program on this population. Our comments are keyed to the numbering in the RFI.

### **2.A.1 Needed care**

Data collection, reporting, and oversight. In order to identify whether health care and services are made equitably available requires robust data collection and reporting on the basis of race, ethnicity, sex, sexual orientation, gender identity, age, disability, geographic location, and other factors. Most importantly, intersectional data for all demographics should be reported. Individuals with intersecting identities are more likely to experience compounded or different forms of inequities, and enhanced reporting of intersectional data will reveal those for specific populations where the single-demographic data does not. Data collection and reporting must occur at every level including: enrollment in Medicare Advantage, prior authorizations, receipt of needed care, appeals and grievances, and disenrollment from Medicare Advantage.

Consistent data collection and reporting aids health plans in identifying disparities and then formulating specific strategies to address those disparities. Data can also help CMS to hold plans accountable for ensuring equitable access to needed care. With consistent data collection, CMS can put in place payment methodologies that incentivize plans to address disparities that emerge based on reported

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data. For example, today under the Hospital Readmissions Reduction Program (HRRP), hospitals receive a reduced reimbursement when individuals with specific health care conditions are readmitted within 30 days of hospital discharge. Similarly, CMS could reduce health plans' capitation payments, which are already risk adjusted for dual eligible status, if plans are not equitably making needed care available to enrollees. It should be expected that health plans are providing care to enrollees in an equitable manner, particularly when plans are receiving higher capitated payments that account for higher health care needs.

Health Equity Index. We support CMS employing a health equity index as a methodological enhancement to the Star Ratings that summarizes Medicare Advantage contract performance, as was proposed in CMS's Advance Notice for Methodological Changes for Medicare Advantage payments in Part C and Part D for calendar year 2023. In addition to "social risk factors," we continue to urge CMS to also explicitly include race and ethnicity in the health equity index as well as other demographic factors such as age, sexual orientation, gender identity, and primary language. Utilizing a health equity index as a means of measuring a Medicare Advantage plan's performance would incentivize plans to affirmatively ensure equitable access to needed care.

### 2.A.3 Screening, documenting, and furnishing health care informed by SDOH

Screening tools. CMS should provide Medicare Advantage plans with screening tools for social determinates of health (SDOH) that mitigate bias. Currently available standardized screening tools, including automated or algorithm-based tools, are prone to bias and have the risk of perpetuating health inequities. Some bias-mitigation techniques that CMS can require health plans to pursue include (1) implementing a human-in-the-loop approach, where any screening tool decision is passed to a human decisionmaker; (2) ensuring adequate diversity in the teams that develop and implement screening tools; and (3) requiring transparency in the development of the screening tools, including the ability to explain to stakeholders what information is being used in the screenings and why.

We also encourage CMS to actively engage with a diverse group of stakeholders, including data scientists and researchers, advocates and self-advocates from various affinity groups, health care professionals, social services professionals, and developers of similar tools that have been vetted for equitable results.

It is also important to note that a screening tool that is equitable in its development is incomplete without culturally-competent administration. Plans should be required to identify social services providers and health care providers that understand the needs of individual members and with which the member feels comfortable and safe to administer the screening. Further, plans must reimburse these providers for conducting the screening.

Addressing SDOH. In addition to screening, CMS should require Medicare Advantage plans to partner and contract with community-based organizations that can directly address SDOH including, for example, legal services organizations, housing and homeless organizations, nutrition/food organizations, and income support organizations. CMS should require that plans are contracting with providers in marginalized communities and rural areas and provide Medicare Advantage plans with tools and best practices in carrying out this requirement. For example, in the Department of Health and Human

Services (HHS) Equity Action Plan, HHS outlined how different strategies need to be employed to ensure greater diversity in HHS grant applicants and awardees including additional technical support in the application process and streamlined reporting requirements. Similarly, Medicare Advantage plans should be utilizing a wide array of strategies to contract and partner with community-based organizations that increase the diversity of providers the plans are working with.

Screening for Medicare Savings Program Eligibility. As part of the SDOH screening process, all Medicare Advantage plans should be required to ask preliminary screening questions for Medicare Savings Program (MSP) eligibility for all members who are not already dual eligibles. Plans should have processes in place to direct individuals who appear potentially eligible for MSPs or other Medicaid programs to appropriate application channels.

## 2.A.4 Language access

Interpreter services. Currently, CMS requires that plans must have interpreters available for customer service lines. There also is a general requirement to provide needed interpreter services. The current [NPRM](#) proposing regulations to implement Section 1557 of the Affordable Care Act also provide helpful standards with respect to when interpreter services are required and quality standards for interpretation.

We ask that CMS, using the 1557 regulations as a starting point, provide plans with more specific regulatory framework, as well as offer more detailed guidance and technical assistance to apply 1557 norms to the specific circumstances of Medicare managed care.

The proposed 1557 regulations would require that covered entities have plans in place to address their language access obligations. We ask that CMS put meat on the bones of that requirement, specifically addressing its application to Medicare Advantage. For example, Medicare Advantage plans should be required to have systems in place to ensure that providing interpreter services is easy for network providers and does not add to provider costs. Other issues include how language needs of LEP members are identified; reasonable criteria to decide when telephone interpretation versus in-person interpretation is appropriate (recognizing the wide variability in the mix of plan membership, the availability of local language resources and many other factors); addressing language needs in supplemental services such as NEMT, congregate activities, etc.; and cultural competency training for Medicare Advantage plan staff and network providers.

Document translation. We ask CMS to revisit current 42 C.F.R. § 422.2267(a)(2) and its companion regulation for Part D, 42 C.F.R. § 423.2267(a)(2), which require translation of certain marketing and communications materials “into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area.” With very few exceptions, this standard means that the translation requirement applies only to Spanish.

Because the measure is a percent without any reference to the absolute number in individuals in a service area, this standard leaves significant swaths of LEP individuals, particularly those in large diverse service areas, without access to any translated materials from their Medicare Advantage plans. For example, both Los Angeles County and New York City have larger Chinese speaking populations than San Francisco, yet because percents alone determine translation responsibilities, Medicare Advantage plans

in San Francisco are required to translate documents into Chinese but those in Los Angeles and New York City are not. The inequities are even greater when looking at Part D plans that serve entire states such as California where despite significant LEP populations statewide, Part D plans are only required to translate documents into Spanish.

For both translation and interpretation, we also ask that CMS increase its oversight of plan performance. Through secret shopper testing of language access, monitoring of language access grievances, focus groups and other measures and hold plans accountable for compliance with language access requirements.

### 2.A.7 Food and nutrition-related supplemental benefits

Food and nutrition-related supplemental benefits can be of great value in addressing the social determinants of health and in meeting basic needs of individuals aging in the community. If, however, items such as grocery debit cards endanger income eligibility for programs like Medicaid or SNAP, that loss can far outweigh any Medicare Advantage plan benefits.

Justice in Aging strongly urges the Center for Medicare to work with the Center for Medicaid and the Department of Agriculture to obtain clarity on the impact of food-related debit cards on income eligibility for these programs and to ensure that eligibility requirements align so that positive actions on the Medicare Advantage side do not cause unintended negative consequences for Medicaid or SNAP benefits. The need for coherent policies across programs to support independent living in the community is particularly acute for low-income individuals who are members of D-SNP plans and who could lose Medicaid coverage, and thus their membership in the very D-SNPs providing the food benefits, if the value of debit cards were subject to Medicaid income counting rules.

### 2.A.8. Physical activity related supplemental benefits

We appreciate that CMS is looking into the availability and usage of physical activity related supplemental benefits and urge the agency to take a hard look at the usage and value of this benefit, particularly because gym memberships are major selling points for Medicare Advantage plans.

Questions to explore in measuring the value of the benefit include: an equity review of the extent to which these benefits are conveniently available in disadvantaged communities; the level of uptake among different population groups; the extent of program adherence by plan members; and the evidence available on member satisfaction with the benefit and on the benefit's impact on health outcomes.

### 2.A.9 SNPs

Beneficiary protections. Today there is huge variability in the extent to which SNPs, and particularly D-SNPs, tailor care for enrollees. Much depends on state actions--what expectations the state sets and what parameters the state imposes, particularly in State Medicaid Agency Contracts (SMACs). Also important is how much the state works on the Medicaid to facilitate coordination with Medicaid services.

We applaud the D-SNP regulations recently adopted by CMS as a good start. The regulations provide clarity on requirements for different types of D-SNPs, remove several technical barriers to oversight of D-SNPs, and begin to set federal minimums for certain beneficiary protections in D-SNPs. We encourage CMS to build on that foundation and develop a fuller, more precise regulatory regime for D-SNPs moving forward, particularly with respect to beneficiary protections. Already one in four dual eligible individuals belong to D-SNPs and significant growth is coming, particularly in states that had participated in the Financial Alignment Initiative. While we recognize that many details of D-SNP design and oversight will vary based on state Medicaid considerations and the extent to which states choose to invest their resources in D-SNP models, it is important that, no matter the state, D-SNP enrollees can count on strong basic protections with respect to supplemental benefits, networks, and other key elements in D-SNP design and operation.

Supplemental benefits. In strengthening the regulatory regime for D-SNPs, we ask that CMS look particularly closely at supplemental benefits, ensuring that they neither duplicate nor supplant benefits under Medicaid, and that dual eligible enrollees can easily navigate between D-SNP supplemental benefits and complementary Medicaid benefits, e.g., having dental providers who belong to both networks, having the same number to call for D-SNP NEMT when it supplements Medicaid NEMT, etc.

We particularly ask that CMS ensure that supplemental benefits not work to erode rights to Medicaid benefits. 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. 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. Supplemental benefits should never supplant a robust Medicaid package.

We also strongly urge CMS require D-SNPs to collect and report demographic data on who is receiving supplemental services and to what degree in order to identify disparities and address them.

Ombuds. We continue to urge CMS to develop an ombuds program for dual eligible enrollees in D-SNPs or, more generally for dual eligible individuals in a state. The ombuds program in the Financial Alignment Initiatives was one of the demonstration's clearly successful innovations, both shortcutting complexities in addressing individual beneficiary concerns and identifying systemic issues. We urge CMS to identify and develop funding sources for dual eligible ombuds programs in every state.

In addition to its regulatory and oversight role, we encourage CMS to continue to devote significant resources to technical assistance to states and D-SNP plan sponsors, including sharing of best practices, assistance with data exchange issues among the parties, development of model SMAC language and other hands-on efforts to improve functioning and encourage improvements in D-SNP programs. We believe that this kind of proactive engagement with partners, though resource intensive for the agency,

has been critical to improvements in the D-SNP program and also provides an avenue for CMS to identify structural problems early.

### 2.B.1 Expand Access: coverage and care

The RFI asks for ways to assist individuals in effectively choosing among Medicare coverage options. In our view, in the current structure, it is simply impossible for individuals to make a genuinely informed choice. They face far too many choices with too many variables. The [Kaiser Family Foundation](#) reported that in the 2022 plan year, the average Medicare beneficiary had access to 39 Medicare Advantage plans, more than double the number of plans per person in 2017. In 25 counties, individuals faced 66 or more plan choices.

These numbers combined with the wide—sometimes insignificant, sometimes very significant—variability in plan design renders market choice practically meaningless. Improvements in the plan finder are helpful on the margins, but there needs to be more uniformity in benefit options—not necessarily as rigid as with Medigap but still uniformity standards that allow reasonable comparisons. SHIPs, particularly if better funded and staffed, can certainly help but they currently reach a small fraction of beneficiaries. Star ratings, which ought to offer guideposts, are of limited value, both because of rating inflation and because many quality measures reflect performance at the contract level, muddying plan level analysis. It is not surprising that most beneficiaries rely on [advertising \(which feeds into brokers\), word of mouth and brand loyalty](#). Once enrolled, [inertia](#) keeps most plan members from even considering change.

We ask that CMS recognize that the Medicare Advantage market needs a major overhaul to ensure that beneficiaries face choices among high quality plans and that they have the means to make rational comparisons. Justice in Aging urges that CMS rein in the number of plan offerings, particularly the number of different plans offered by the same plan sponsor. We also ask that variations in plan design be limited and categorized so that individuals have manageable choices. In addition, CMS must significantly strengthen regulation of Medicare Advantage advertising, particularly third-party TV ads. Rules must be much more prescriptive and rigorously enforced. Choices among taxpayer-funded health care options need to be promoted in responsible ways, not using the same techniques that sell mattresses or questionable food supplements.

### 2.B.2 Help in understanding choice between Medicare Advantage and Original Medicare

Freedom of choice is a central value in Medicare, including the choice between Original Medicare and Medicare Advantage. We see several factors inhibiting exercise of choice in Medicare and understanding by beneficiaries of the differences between Original Medicare and Medicare Advantage.

One important factor is commission rates. Agents and brokers receive significantly more remuneration when they sell a Medicare Advantage product and thus are incentivized to promote Medicare Advantage products over Original Medicare. It is not surprising that the majority of advertising also promotes Medicare Advantage options.

Enrollment rules and restrictions also tip the scales. The choice to enroll in Medicare Advantage is simpler than the choice to leave. Plans can drop an individual's providers from the network but for most of the year, beneficiaries cannot leave. Similarly, plans can change posted prescription drugs as frequently as every two weeks, yet plan members do not have the option to leave the plan in response. Further, after an initial trial period has passed, individuals in many states can effectively be locked into Medicare Advantage because of excessive costs to obtain Medigap coverage. Currently, the broad comparisons tend to be limited to two domains: 1) Original Medicare access to all Medicare providers versus Medicare Advantage's use of provider networks and prior authorizations; 2) Medicare Advantage approval to provide supplemental benefits not available in Original Medicare. There is much less attention to, for example, cost comparisons for a hospital stay or for other typical important health events. It would be helpful if CMS could require plans or brokers to discuss items such as these that are central to health and not just focus on the "extras." We ask CMS to work to address all of these issues, either through administrative action, enhanced oversight or, when required, through proposing legislative changes.

We also ask that CMS take steps to improve consumer education on Medicare choices, both in its own outreach to consumers and in what it requires of plans, agents, and brokers. CMS could, for example, require brokers to walk consumers through a couple of scenarios such as hospitalizations and Skilled Nursing Facility stays and compare how choices and costs could differ. We also ask for more transparency about marketing misconduct, significant consequences for violations of marketing rules.

With the increasing number of Accountable Care Organizations (ACOs) and the opportunities that they offer for targeted supplemental services within Original Medicare, it seems to us that more education of SHIP counselors as well as agents and brokers on the rudimentary elements of the ACO model is important so that they can help consumers understand the broader Medicare landscape. More consumer education on ACOs and how they work would also give beneficiaries more context in which to discuss with their providers what enrollment options would be best for them.

## 2B.6 Networks

From advocate experience with network rules, we wish to highlight four areas where we believe CMS should put additional attention.

Incorporating equity into network standards. There are several ways in which CMS can better incorporate equity in looking at plan networks. We offer a few examples.

Legislation recently enacted in California, [S.B. 923](#) serves to address network concerns of transgender, gender non-conforming and/or intersex (TGI) beneficiaries, and offers a model for designing plan requirements that would begin to address these issues. The legislation requires health plan staff who interact with patients to undergo TGI cultural sensitivity training and also require plans to maintain and update a list of contracted providers who offer and provide gender-affirming services. It further requires the state's Medicaid agency to convene a working group to develop a quality standard for patient experience to measure cultural competency for TGI patients.

Similar basic requirements for cultural sensitivity training and up-to-date lists of accessible providers would also be appropriate for beneficiaries with disabilities. Moreover, plan network requirements

should include disability access standards. Plan members with disabilities should not have difficulty in finding plan providers without barriers to wheelchair access, with scales that can weigh them without discomfort, with examining tables that can adjust to their needs, etc.

CMS should also collect demographic data about plan providers. Such data, both at the plan level and in the aggregate for Medicare Advantage more broadly, will provide a starting point for CMS and plans to explore whether plans are successfully recruiting providers that serve specific racial or ethnic communities and if not, to explore the reasons for deficiencies. [Experience with the Financial Alignment Initiative](#) has shown that, when networks do not include community providers, beneficiaries in those communities opt out of participation in very large numbers.

Ensuring access to specialists for unique needs of specific populations. Current network adequacy rules set standards for relatively broad specialty areas but do not (and often cannot) account for all levels of sub-specialization, particularly sub-specialties that may be important for particular marginalized subgroups. While some of some gaps are inevitable, they should be accompanied by liberal opportunities to use out of network providers. We hear from advocates that this is not always the case. For example, the universe of surgeons experienced in certain complex gender-affirming surgeries is relatively small and many do not belong to plan networks. However, advocates have reported instances where plan members were denied opportunities to use out of network providers and, instead, were steered by their plans to significantly less experienced providers who were in the plan's network. We believe these issues have arisen as well for people with complex disabilities. We urge CMS to, at least, track appeals of requests for out-of-network providers with the goal of identifying if plan denials create inequities.

Setting network requirements for supplemental benefits. Currently CMS has no network adequacy requirements for supplemental benefits and thus no way to measure whether a plan has enough dentists or audiologists, for example, to provide the benefits promised to members. We urge CMS to develop adequacy standards for supplemental benefit suppliers, particularly for those like dental, hearing, and vision that are widely offered.

Narrow networks and adverse selection. We hear from SHIP counselors and other advocates that one of the frequent reasons that plan members seek to disenroll is that they had a significant health event and found that the plan's network was not appropriate to meet their new medical need. This scenario is most likely to happen with D-SNPs, which tend to have narrower networks. As a result, at a time when individuals are most likely to benefit from the care coordination that D-SNPs should be providing, and when they would also be most expensive for the D-SNP, they leave. We urge CMS to review voluntary plan disenrollments to determine the extent of this back-end adverse selection and consider changes in network adequacy rules to avoid these outcomes.

## 2.B.7-10 Supplemental benefits

The flexibility given to Medicare Advantage plans to offer supplemental benefits offers both opportunities and challenges. Supplemental benefits are an important tool to provide person-centered care and specifically to address Social Determinants of Health (SDOH). They also are a powerful marketing tool for Medicare Advantage plans.

Currently, we know which supplemental benefits a Medicare Advantage plan is offering, but we know little else. We do not know how many plan members are actually receiving these benefits, which benefits they are receiving, and whether supplemental benefits are equitably available to all plan members. Without these basic data points, it is impossible to move to the next step—determining which benefits are making a difference in the health of plan members.

We urge CMS to require uniform data collection by Medicare Advantage plans for supplemental benefits. Categories need to be specific and not general buckets that mask the nature of the services offered. Data must be collected so that information can be sorted by demographic categories including race, ethnicity, language, SOGI status, disability, age, and geographic region.

We also ask that CMS carefully monitor plan choices of benefits offered. We note for example, that, according to a [Kaiser Family Foundation analysis](#), a significant majority of plans do not offer Special Supplemental benefits for the Chronically Ill (SSBCI), but almost all offer some dental, vision, hearing, and fitness benefits. Even Special Needs plans, though offering SSBCI benefits at a higher rate than standards Medicare Advantage plans, still have limited offerings. See also [data analysis of ATI Advisory](#). CMS should ensure that benefits design primarily address the more important needs of Medicare Advantage plan members, rather than primarily serving marketing goals. It also is important that benefit design not skew to those who are healthiest.

## 2.D Support affordability and sustainability

As a general comment, we note that the current rules shield Medicare Advantage plans from having to share with CMS or other stakeholders information about how plans compensate their providers. This huge gap in transparency makes an analysis of the effectiveness and value of the program model particularly difficult. It also makes it difficult to assess the accuracy of risk adjustment payment formulas. An additional barrier to analysis is the current lack of tracking of use of supplemental benefits, particularly use by those with high risk adjustment codings.

With regard to risk adjustment to promote equity, we reiterate that Medicare Advantage plans should as a foundational principle be held to a standard of delivering care equitably. Medicare Advantage plans to date already receive risk adjusted capitations to account for dual eligible status. Health plans should not be additionally compensated to address discrimination in the health care system that the plans themselves have perpetuated. Instead, they should be held accountable for meeting their obligations to provide care equitably. CMS should review its payment and quality policies to ensure that those policies achieve those accountability goals.

### 2.D.3 Impact of Medicare Advantage expansion writ large

The trends of vertical integration throughout the health care system, combined with consolidation among health insurers, are leading to increasing concentration of ownership among plan sponsors, creating near oligopolies in some Medicare markets. On top of this, CMS is steward of additional billions of dollars in federal funds supporting Medicaid managed care, which has grown exponentially in recent years, and Marketplace plans created as the result of the ACA. In these three programs, CMS oversight of plans has, to date, been siloed and the agency's approach has struggled to keep up with the growing role and power of an increasingly concentrated pool of commercial insurers in the programs it

administers. We urge CMS, as it looks to the future of Medicare Advantage, to start thinking of plan sponsor organizations as more like public utilities and to coordinate its oversight responsibilities more broadly across programs, devoting more resources to that oversight, and requiring more transparency and stricter accountability from those it regulates.

## 2.E Engage partners

Ongoing dialogue among CMS, plans and other stakeholders, including especially beneficiaries and their advocates, is absolutely essential for both smooth operation of the program and good policy decisions. From experience with the Financial Alignment Initiative and other programs, our view is that multiple channels are needed. Large stakeholder meetings are useful for sharing program development and changes but often have limited value in obtaining consumer feedback. We urge several additional approaches.

First, there is a need for CMS and plans to hear unfiltered feedback from consumers. This can be done effectively through well-structured Consumer Advisory Councils, focus groups and smaller information sessions with beneficiaries. It is particularly important that different voices are heard, including especially the voices of those with limited English proficiency and disabilities.

Ongoing periodic meetings with advocates also are important, both locally and nationally. In Medicare Advantage, there is significant benefit in routine meetings among CMS regional office staff, plan personnel and advocates familiar with Medicare Advantage. In the Financial Alignment Initiative context, meetings among Ombuds, CMS, and plans created useful working relationships that identified systemic issues and also simplified resolution of individual issues. At the national level as well, an ongoing dialogue among CMS officials and advocates can be very fruitful.

## Conclusion

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact Georgia Burke, Director of Medicare Advocacy, at [gburke@justiceinaging.org](mailto:gburke@justiceinaging.org).

Sincerely,



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