



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 through regulations.gov

Dear Centers for Medicare and Medicaid Services,

The Center for Consumer Engagement in Health Innovation at Community Catalyst respectfully submits the following comments on the proposed rule for Medicare Advantage and Part D.

[Community Catalyst](#) is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill.

[The Center for Consumer Engagement in Health Innovation](#) at Community Catalyst focuses on health system transformation and bringing the community experience to the forefront of health. The Center works directly with advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate individuals' experience into the design of their systems of care. We also work with state and federal policymakers to spur change that makes the health system more responsive to people, particularly those who are most vulnerable.

Community Catalyst appreciates that CMS has sought to tighten and clarify requirements concerning Dual-Eligible Special Needs Plans (D-SNPs) and that it has throughout aimed to focus on beneficiary experience and beneficiary needs. Our comments are generally supportive and offer suggestions where CMS can provide additional specificity. We understand that CMS is exercising caution in some cases by not being prescriptive. However, given the exponential growth of D-SNPs, sufficient detail is necessary to protect the over four million dually eligible individuals in D-SNPs and those expected to join as the D-SNP landscape expands.

Enrollee Participation in Plan Governance (§ 422.107)

We are encouraged to see a requirement that all D-SNPs establish an enrollee advisory committee and that D-SNPs consult with advisory committees on issues related to health equity. We strongly support this requirement and share additional comments for consideration to strengthen the impact of the committees and ensure they are diverse and inclusive in nature.

As noted in the proposed rule, advisory committees are an important component of consumer and community engagement. In order for them to be effective, they must be thoughtfully designed to ensure enrollees have the ability to give meaningful feedback and see it implemented. Effective advisory committees include the following:

- Successful advisory committees acknowledge the power imbalance between enrollees and decision-makers and provide committee participants the tools they need to fully and equitably participate. This entails financial support (e.g., stipends or reimbursement for time and travel), technical support, and professional assistance.
- Advisory committee participants should be trained, which at a minimum should brief them on the core knowledge needed to engage in conversations about program design and administration.
- Enrollees, not state authorities, should lead the committee process. At least 50% of committee membership should be dually eligible individuals and/or their caregivers, and should reflect the demographics of enrollees.
- Agendas should be led by and co-created with enrollees, and the issues covered should reflect the top concerns and priorities of the enrollees themselves.
- There also needs to be a clear feedback loop for advisory committees to see how their feedback is being considered and implemented. Instituting a monitoring and evaluation plan on the effectiveness, equity, and responsiveness of the advisory board is key.
- Advisory committees must meet regularly (2-3 times a year at a minimum) with publically available agendas and materials.
- There must also be multiple enrollee advisory committees in larger states where D-SNPs under the same plan sponsor are offered in multiple counties to ensure meaningful representation. Otherwise, the committees are simply tokenism, offer little value and perpetuate power imbalances and inequities.
- Plan staff should create an inclusive environment whereby enrollees with limited English proficiency are welcomed. This entails ensuring interpreters are made available, materials are in the enrollee's preferred language. In regions/counties where English is NOT the primary language, the committee itself must communicate in the language most spoken by enrollees in that region/county.

The existence of an advisory committee is not itself a demonstration of enrollee input. Advisory committees must be intentionally designed and integrated into overall program structures to be considered true enrollee engagement. Advisory committees also must have decision-making authority. Community Catalyst's publications, [Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities](#) and [Supporting Meaningful Engagement through Community Advisory Councils](#) provide further detailed information on how to build a meaningful advisory committee.

In addition to Enrollee 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](#).

Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessment (§ 422.101)

We strongly support these proposed changes, as incorporating the social drivers of health (SDOH) into health assessments promotes person-centered care. For individuals, social needs questions can help determine eligibility decisions, make clinical decisions, and more effectively manage care. Social needs assessments also offer important population-level information that can help inform payment reform and future innovations targeted to historically excluded and/or underserved populations.

However, social needs assessments are not effective in isolation. In order to meaningfully improve outcomes for enrollees, social needs assessments must be paired with strong connections to community-based organizations and providers that can address the identified unmet need. This also includes more innovative approaches to including community-based organizations on payment methodologies. Not only is screening without a strong referral and navigation system ineffective, it is unethical, as asking for sensitive information without a solution puts high-need individuals at risk and can undermine their trust with their providers.

Screening is one approach to addressing the social drivers of health in the health system, but certainly not the only way. In addition to SDOH data collection, Community Catalyst encourages health systems to continue to build meaningful relationships with their communities to sustainably invest in their population's long-term health outcomes. With strong connections to both beneficiaries and community-based organizations, all members of the community with unmet social needs can better access the resources and services available to them. These relationships must also be paired with financial investments in community infrastructure and services, which can be accomplished by value-based payments and flexible spending arrangements. Otherwise, inequitable distribution of existing resources, heightened by an uptake in SDOH screening, could inadvertently create new or exacerbate existing health disparities and inequities.

In order to ensure a strong service referral and navigation pipeline, health providers, particularly safety-net providers, need support. Social needs screenings are most effective when there's a high level of trust, so providers need specialized training (such as strengths-based assessment) and utilizing peer supports, such as community health workers. The community-based organizations providing services also need funding to ensure they have the capacity to take on new referrals. If CMS is unable to provide this funding independently, we highly encourage CMS to consider integrated funding opportunities with other federal partners (e.g., Housing and Urban Development, Education, and Transportation departments) or braided and blended funding approaches.

Enrollees and communities must be engaged throughout the design and implementation of a social needs assessment. Enrollees should have ample opportunities for feedback and oversight.

This includes an evaluation of the effectiveness of a given social needs assessment, for all populations screened, and a referral and navigation system in meeting the needs identified by beneficiaries.

Community Catalyst's publication [Screening for Social Needs](#) provides detailed insights on effective design and implementation of social needs assessments.

Finally, it is essential that demographic data be collected during the time of the Health Risk Assessment, and made publicly available. This information can help facilitate a culturally sensitive care planning process for the enrollee. Demographic data includes, but is not limited to: race, ethnicity, age, sex, gender, gender inclusion, sexual orientation, language, and disability.

Refining Definitions for Fully Integrated and Highly Integrated D– SNPs (§§ 422.2 and 422.107)

a. Exclusively Aligned Enrollment for FIDE SNPs

Community Catalyst is encouraged to see the proposal for exclusively aligned enrollment for FIDE-SNP. We strongly recommend trainings for benefits counselors as well as community partners (at least once a year) on exclusively aligned enrollment and its process; this includes sufficient investment in resources for counselors and community partners. Furthermore, there should be an intentional effort to ensure that enrollees, including those with limited English proficiency, understand how their enrollment works. Robust outreach and education are critical to ensuring a well-developed and highly functioning enrollment supports infrastructure. Community Catalyst's publication, [Person-Centered Enrollment Strategies for Integrated Care Toolkit](#), provides additional details on creating person-centered enrollment practices.

We also recommend that exclusive alignment apply to HIDE-SNPs. We do not think a delay to 2025 is required, at least for plans newly qualifying for FIDE-SNP or HIDE-SNP status. For new FIDE-SNPs or HIDE-SNPs, we recommend that plan compliance begin in the initial contract year.

Additional Opportunities for Integration Through State Medicaid Agency Contracts (§ 422.107)

a. Limiting Certain MA Contracts to D– SNPs

Community Catalyst strongly supports having separate contracts for D-SNPs to facilitate a more complete picture of plan performance and network adequacy that is specific to dual eligibles. If CMS limits itself to the current proposal, we ask that CMS use the process as a template for a wider required, not optional, separation of D-SNP contracts in the future. Given the vulnerability of the population served by D-SNPs it is especially important that regulators have every tool available to monitor their performance.

We recommend that if a State seeks to require MA organizations to establish a contract that only includes one or more D–SNPs with exclusively aligned enrollment within a State, then the State, as well as MA organizations, should have to explicitly include consumer and community level

stakeholders. It will be, particularly, important to engage dually eligible individuals and their caregivers who represent BIPOC (Black, indigenous, and people of color) communities.

With regards to CMS's request to bring forward any special concerns if they established a crosswalk 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. Furthermore, it will be important for plans to demonstrate how they have communicated this shift to the beneficiary, in plain language, the similarities and differences between the two contracts, and where they can go for further support (e.g. options counseling).

b. Integrated Member Materials

Community Catalyst strongly supports integrated member materials for exclusively aligned D-SNPs. Many enrollees are not aware of their integrated care options, and it is often challenging and rare for them to find clear sources of information explaining exactly what Medicare and Medicaid benefits are available to them through a given care plan. We welcome the proposed change, as it simplifies the information gathering process for beneficiaries. States should utilize their authority to standardize materials and ensure consistent messaging whenever possible.

While integrated materials are an excellent step forward, greater effort is needed to ensure the information itself more simplified and understandable to those at all levels of health literacy. States [should test different messaging](#) with dually eligible individuals, including dually eligible individuals from diverse backgrounds and/or those with limited English proficiency, to create understandable materials with consistent messaging. In order to design messaging that resonates with dually eligible individuals, states should collaborate with community-based organizations and enrollment assisters, as they tend to be trusted sources of information for beneficiaries. We also urge CMS to include a provision that translation requirements for integrated member materials to be set at either the state or federal standard, whichever is more favorable to the beneficiary.

c. Joint State/CMS Oversight

Community Catalyst supports CMS's proposal to provide States with access to the HPMS in order to facilitate monitoring and oversight of D-SNPs. Better coordination between States and CMS could potentially lead to less fragmentation and higher level of integration, which is ultimately a benefit for the beneficiary.

We propose that with this access States can also access to see member complaints. We propose that this information is aggregated and stratified and that this information is utilized by health plans for quality improvement and performance purposes. We also would like to reiterate the importance of de-identifying information that could reveal the identity of the member that has made the complaint, to ensure that their privacy is upheld and to decommission any channels that could lead to or be perceived as member retaliation.

We strongly recommend interoperability between state monitoring systems and HPMS. Only having access to HPMS may still provide barriers to utilization. States who choose to use HPMS should be given training, supports, and resources to integrate their systems for seamless data

transfers, that upholds ONC's [United States Core Data for Interoperability](#) version 2 (USCDI v2) interoperability standards to support the electronic exchange of data (e.g., SDOH and SOGI).

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 or FIDE SNPs, is the best determinant for requiring plans to provide unified appeals and grievance procedures. Because of the historical development of their Medicaid programs, numerous states have significant carve-out 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 from 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 Durable Medical Equipment and home health.

We support and strongly encourage CMS to read comments submitted by Justice in Aging on this matter.

Comment Solicitation on Coordination of Medicaid and MA Supplemental Benefits

We recommend CMS provide more specificity in § 422.102 as well as in marketing rules and state contracts about whether a benefit is really “extra” or is something already covered by Medicaid or Medicare. As noted by Justice in Aging, a persistent issue 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.

Converting MMPs to Integrated D– SNPs

We are deeply concerned and do not support the proposal put forward to convert MMPs to D-SNPs, for all the reasons the proposed rule outlines. The flexibilities available in the financial alignment initiative (FAI), particularly the single payment stream and opportunity for shared savings 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 by CMS. A particular concern we would elevate is the mass confusion that beneficiaries would experience as they navigate potentially changing health plans, benefits, and the structure of those plans. 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. It is also important to keep in mind that the potential for less integration is a move away from reducing disparities and creating an equitable system of care for a particularly vulnerable and complex population, where a majority are marginalized within the healthcare system and experience health injustices.

Marketing and Communications Requirements on MA and Part D Plans To Assist Their Enrollees (§§ 422.2260 and 423.2260, 422.2267, and 423.2267)

Community Catalyst welcomes the proposed rule's addressing of the deceptive and confusing marketing tactics that are employed by third-party marketing organizations to individuals eligible for D-SNPs and MA plans.

The existing regulatory environment has allowed the deceptive marketing tactics to flourish, and the proposed rule brings in needed oversight. In the current marketing environment, eligible beneficiaries are inundated with advertising and marketing materials that do not clearly and accurately clarify the level of integration and benefits available in a given plan. The volume of plans available in many markets makes it difficult for beneficiaries to compare their options and find a truly integrated plan that fully meets their needs.

We are pleased to see the proposed rule's reinstating the inclusion of a multi-language insert in specified materials to inform beneficiaries of the availability of free language and translation services.

Many linguistically diverse communities have remained underserved by integrated care due to the lack of translated materials. These improvements are an important first step in improving access, but more action is needed. In addition to informing beneficiaries of the availability of language and translation services, states need to invest in the direct service providers who provide these services to ensure they are adequately resourced. Translated marketing materials on their own are insufficient – interpretation services need to be readily available at all stages of the enrollment and subsequent care coordination process. Marketing materials should also be vetted by enrollee advisory committees and/or enrollee focus groups before publication.

We are also pleased to see that the rule codifies ID card standards, which ensures cards from plan to plan contain the same information in the same locations. This ensures consistency for enrollees regardless of what specific health plan they are enrolled in.

ID cards are important for dually eligible individuals to identify the fact they are in an integrated plan. While the terms “integrated” and “care coordination” do not always resonate with dually eligible individuals, the idea of using one specific card for both Medicare and Medicaid resonates. Ensuring ID cards are standardized eliminates some confusion for beneficiaries.

Community Catalyst appreciates CMS's correction to include a requirement that plans post instructions about how to appoint a representative on their website, which would require plans to include a link to a downloadable version of the CMS Appointment of Representative Form.

Beneficiaries often face confusion when there is a need to appoint a representative, and many are not aware that it is an option available to them. Requiring plans to post information on their websites is a good first step, but many dually eligible people do not have internet access and are not receiving information about their health care through internet sources. In order for beneficiaries to be adequately informed about their right to appoint a representative, additional community outreach is essential. This information should be part of training curriculums for

counselors, community health workers, and community partners as well as outreach efforts led by CMS and the State.

Regarding website posting of enrollment instructions and forms, beneficiaries have reported confusion and issues with completing the enrollment process, and any effort to make the process more accessible and transparent is a positive one. However, policymakers must keep in mind that many dually eligible individuals do not have internet access or do not use internet sources to access information about their health care. In addition to website information, outreach to enrollment assisters and other trusted sources of information is necessary to ensure all beneficiaries have knowledgeable sources of information to support them through the enrollment process.

Community Catalyst has completed research that directly engages with beneficiaries about their experiences enrolling in integrated care. The publications [Listening to Dually Eligible Individuals: Person-Centered Enrollment Strategies for Integrated Care](#) and the [Person-Centered Enrollment Strategies for Integrated Care Toolkit](#) provide detailed insights about how marketing and communications can be improved for dually-eligible beneficiaries.

Items for CMS consideration - Ombudsman Program

One of the major successes of the Financial Alignment Initiative (FAI) was the use of an ombudsman program to assist individuals in navigating MMPs. We strongly encourage CMS to review the comments on this submitted by Justice in Aging on this matter.

We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues in the future.

Sincerely,

DocuSigned by:
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