



March 5, 2018

Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted via: www.regulations.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter Docket # CMS-2017-0163

Dear Mr. Kouzoukas:

Community Catalyst is pleased to submit comments to the CMS 2019 Advance Notice and Call Letter. We focus our comments on certain sections in the draft Call Letter that impact Medicare-Medicaid enrollees (dual eligibles).

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer 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 the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those who are most vulnerable. We have been working to improve Medicaid and Medicare for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders.

Section II: Part C

Health Related Supplemental Benefits

We are hopeful that the broader definition of health related supplemental benefits proposed in the Call Letter will help to appropriately meet member needs and prevent avoidable injury or illness. While the Bipartisan Budget Act (BBA) of 2018 eliminates the requirement that all supplemental benefits be primarily health related, the proposed changes still have the potential to be important

and valuable. The 2018 BBA provisions do not take effect until 2020. The changes proposed in the Call Letter will give CMS and plans a year in which to start an expansion of supplemental benefits before the additional provisions of the BBA become operative.

While we are supportive of the proposed changes, we ask CMS to closely monitor their implementation to determine the extent to which the benefits are actually offered and utilized and to ensure that implementation is not directly or indirectly discriminatory. Tracking of benefits and outcomes also will allow CMS to evaluate the efficacy of particular supplemental benefits.

Special Needs Plan (SNP)-Specific Networks Research and Development

We urge CMS to continue to examine the SNPs' network adequacy standards and that SNPs have the flexibility to tailor their provider networks to the needs of the beneficiaries they serve. SNP enrollees have more complex needs and more frequent interactions with the health care system than traditional MA enrollees.

In addition, it is critical that SNP-specific networks do not become too targeted. People in SNPs have various health care needs and while they may have a condition that allows them to be in a specific SNP (namely a Chronic Condition SNP or C-SNP), they may also have another condition that requires health care providers unassociated with the qualifying condition. We are also concerned that certain groups of specialists would only be available in SNP-specific networks, thereby limiting necessary access to specialists for plan members in a non-SNP plan.

Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs

We appreciate CMS' efforts to ensure communications processes are streamlined through better coordination and oversight between CMS and states, including developing integrated model materials. To continue on the improvement path, we would encourage CMS and states to:

- Work with community-based organizations (CBOs), including those that represent communities of color and/or non-English speaking beneficiaries, to ensure a robust and coordinated communication process;
- Consumer test all materials;
- Use plain language and a reading level no higher than sixth grade;
- Use the translation standards that promote the greatest access. As was done in the Memorandums of Understanding (MOUs) in the financial alignment demonstration, where Medicare and Medicaid standards for translation and alternate formats differ, apply the standard providing the greatest access to individuals with disabilities or limited English proficiency.¹ Dual eligibles who are accustomed to receiving communications about their Medicaid benefits in a language or format they can understand should not have to face the challenge of receiving information from their D-SNP that they cannot understand or use.
- Tailor the notices to the individual's circumstances and include only information directly relevant to the purpose of the notice.

We also ask that CMS continue to work to improve other dual eligible-specific notices beyond those listed in the Call Letter and, more generally, to tailor all its notices to the specific

¹ See, e.g., MOU between CMS and California re California Demonstration to Integrate Care for Dual Eligible Beneficiaries, p. 16, available at [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf).

circumstances of the beneficiary. For example, notices sent to those who are already enrolled in the Low Income Subsidy program should not say “you may qualify for Extra Help.”

We recognize that creating clear notices to explain complicated programs presents challenges and would be pleased to work with CMS on this ongoing effort.

Parts A and B Cost-sharing for Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

We appreciate that CMS continues its efforts to obtain full plan compliance with requirements to protect QMBs from improper billing. We also particularly thank CMS for the steps it has taken to make identification of QMBs easier for providers through the HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) system. Given the on-going challenges faced by beneficiaries, we believe that CMS’ continued emphasis in this Call Letter on plan obligations to educate providers and to give them the tools to identify QMBs is fully warranted. Further, we ask that CMS monitor Complaint Tracking Module (CTM) entries to identify plans and plan sponsors that have repeated complaints in order to focus education and enforcement.

Section IV: Medicare-Medicaid Plans (MMPs)

Network Adequacy Determinations

CMS will require MMPs to submit their network information regularly to ensure that each MMP continues to maintain a network of providers that is sufficient in number, variety, and geographic distribution to meet the needs of the enrollees in its service area. We continue to strongly support this requirement. As CMS makes network adequacy determinations for the MMPs, we also urge that CMS ensure that beneficiaries have access to providers that meet their cultural and linguistic needs. All MMPs should also include qualified substance use disorder treatment providers and geriatric providers, including dementia care specialists.

We also encourage CMS to consider, when reviewing the network information, whether the listed providers who speak additional languages can accommodate persons with disabilities and are currently accepting new MMP patients.

Additional Topics

Reducing Health Disparities

We urge CMS to make an ongoing effort to reduce health disparities among Medicare beneficiaries. We ask CMS to:

- Require Medicare Advantage Organizations (MAOs) to train their staff and providers on topics related to health equity. We strongly urge CMS to offer a webinar series on such topics as delivering culturally competent care, language access, and data collection. We would be happy to explore this with CMS and work together to bring these important topics to the provider and plan community.
- Provide data stratified by language, age, gender, sexual orientation and disability status. We appreciate the work to date by CMS to collect and publish data stratified by race and ethnicity, and would encourage CMS to expand this effort.

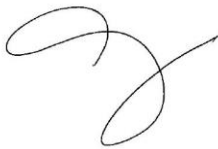
- Provide ongoing updates to the public on progress in implementing the [CMS Equity Plan for Improving Quality in Medicare](#) that was released in 2015 by the CMS Office of Minority Health.

As CMS formulates its policies and programs, we emphasize the importance of actively engaging consumers, advocates and family caregivers. We believe that beneficiaries have a critical role to play in shaping plans and programs, in order to meet their needs. We also encourage CMS to seek input from those consumers and communities who may face most difficulty in having their voices heard.

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We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues in the future. Please do not hesitate to contact me at ahwang@communitycatalyst.org with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,

A handwritten signature in black ink, appearing to be 'Ann Hwang', written in a cursive style.

Ann Hwang, MD
Director, Center for Consumer Engagement in Health Innovation