JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

January 27, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4208-P
P.O. Box 8013, Baltimore, MD 21244-8013

Submitted electronically via regulations.gov

Re: Medicare Program; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)

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 enrollees and populations who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency.

Given our focus and deep expertise on the impact of health care programs on low-income older adults, our comments discuss the effect the proposals would have on people dually eligible for Medicare and Medicaid and on addressing health inequities and disparities. Our comments are keyed to the headings in the Notice of Proposed Rulemaking and are presented in the order discussed there.

II. Implementation of Inflation Reduction Act (IRA) Provisions for the Medicare Prescription Drug Benefit Program

C. Medicare Prescription Payment Plan (§§423.137, 423.2265, 423.2267, and 423.2536)

The new Medicare Prescription Payment Plan (MPPP) offers a powerful tool to manage high prescription expenses for Medicare enrollees who face steep out-of-pocket medication costs at the beginning of the year. The MPPP is one of the key affordability options for Medicare enrollees, along with the Low-Income Subsidy (LIS), Medicare Savings Programs (MSPs), and State Prescription Assistance Plans (SPAPs). As acknowledged by the Centers for Medicare and Medicaid Services (CMS), different affordability options are appropriate in different situations. For example, a person on LIS may have consistent expenses throughout the year, so MPPP may not be appropriate for them.

Justice in Aging strongly supports the proposal to educate Medicare enrollees about the options under LIS, MSPs, and SPAPs in MPPP materials. Specifically, Justice in Aging appreciates that the Notice of Election Approval, Notice of Voluntary Termination, Notice of Failure to Pay, and Involuntary Termination Notice all include information about LIS, Medicare Savings Programs, and SPAPs to help afford medications.[1] **In addition to these materials, Justice in Aging asks that information about these**

affordability programs also be added to materials accompanying the MPPP Election Request form.[2] Adding information early in the process will help educate individuals *before* making an MPPP enrollment decision and direct the individual to the right program for them from the outset.

Justice in Aging also asks that information about LIS retroactivity be added to the Notice of Voluntary Termination; Notice of Failure to Pay; Involuntary Termination Notice; and the Billing Statement.[3] A Medicare enrollee facing prescription medication debt may not realize that accessing LIS can help with *past* prescription costs, not just future ones. Information about LIS retroactivity in these notices would provide timely information to a Medicare enrollee facing prescription bills. For example, for the Notice of Failure to Pay, Justice in Aging recommends that CMS amend 42 C.F.R. § 423.137(f)(2)(ii)(C) as follows[4]:

> (vi) An overview of other Medicare programs that can help lower costs and how to learn more about these programs, including Extra Help and how Extra Help can pay for past prescription costs, the Medicare Savings Programs, the State Pharmaceutical Assistance Program, and a manufacturer's Pharmaceutical Assistance Program.

In some instances, LIS enrollees pay no out-of-pocket costs for covered medications.[5] While outside of the scope of the proposed rule, **Justice in Aging asks that CMS include information about no out-of-pocket costs for certain dually eligible individuals in additional Medicare materials (Medicare Plan Finder and the website "Help paying for drug costs"** [6]**)**.

III. Strengthening Current Medicare Advantage, Medicare Prescription Drug Benefit, and Medicaid Program Policies

B. Network Transparency for Pharmacists

Justice in Aging strongly supports the proposal to inform pharmacies early about whether they are in-network for Medicare Advantage and Prescription Drug Plans. For Medicare enrollees, the pharmacy can be a main point of contact with the health care system, and their pharmacy's network status is key when choosing a plan. The proposed rule would allow people to check in with their pharmacy during open enrollment to ensure that they will be in network come January. For enrollees, especially rural enrollees and enrollees with limited transportation, learning of a pharmacy change ahead of time will help facilitate planning ahead and more informed health care consumers.

F. Administration of Supplemental Benefits Coverage Through Debit Cards §§ 422.2, 422.102, 422.102, 422.111, and 422.2263

Justice in Aging strongly supports CMS's proposals to add new protections for supplemental benefits that are administered using debit cards. Advocates on the ground report that many of their clients are joining MA plans because they are being offered supplemental benefits as debit cards in amounts as high as $300 a month, which for nearly one in five enrollees represents a 20% or greater increase in their monthly income. For the five million dually eligible individuals living on $10,000 or less per year, $300 a month increases their income by more than 35%. Unquestionably, providing individuals with cash benefits is economically beneficial for Medicare enrollees, many of whom are living at or below poverty on fixed incomes and are at risk of homelessness. As such, these benefits induce people to

enroll in health plans without evaluating whether the plan meets their specific health needs, whether the plan offers the most extensive coverage for the least cost, or if their preferred provider is in network with the Medicare Advantage plan. The reward is advertised without an explanation of the potential limits in their use. Stronger disclosures and guardrails are needed to ensure enrollees fully understand what benefits are available to them and how to access them.

Justice in Aging strongly supports the proposed requirement that Medicare Advantage plans offer a customer service support line for members using debit cards. Many questions arise with the use of debit cards, including which items can be purchased, which stores debit cards can be used at, and whether there is a rollover of allowed amounts from month to month. These issues are likely to arise at point of sale which, especially in a hectic store, can lead to confusion, social awkwardness, and stigma. Justice in Aging asks CMS to implement this requirement in a manner most helpful to a Medicare enrollee in these circumstances and resolving issues quickly. For example, CMS should consider requiring customer service to be available in multiple modalities (phone, text, email); available to the store clerk processing the transaction as well as the enrollee; and available with language interpretation (including American Sign Language). Given the widespread concern about how debit cards intersect with housing and other public benefits (addressed in the next paragraph), CMS should require training of staff for this customer service line be aware of the public benefits issue and empowered to escalate systemic issues.

We also support the proposals to require Medicare Advantage Plans to provide enrollees with instructions on the use of debit cards and alternative means of accessing their benefits in the event they cannot use the debit card. The method that plans use to deliver benefits should not impede access to the benefits for which members are eligible.

Justice in Aging strongly supports CMS's proposal to require plans to include information about what items can be purchased with debit cards. Justice in Aging reviewed a number of Explanation of Coverage documents, and found confusing information about what items can be purchased and under what parameters. **Justice in Aging urges CMS to provide templates for this information to be shared and for CMS to monitor compliance, to make such information understandable to Medicare enrollees and their assisters.** Justice in Aging also asks CMS to require Medicare Advantage plans to include a disclosure for HUD recipients about the effects of using debit cards to pay for rent and utilities on their eligibility for HUD assistance.[7]

Justice in Aging partially supports CMS's proposed rule on whether Medicare Advantage plans can mention debit cards or their amounts in marketing. Potential plan enrollees should be protected from marketing tactics that bury restrictions on debit cards and the impact of changing plans in the fine print (or do not offer that information at all). We often hear about consumers making plan choices based on debit card amounts, without understanding implications for their care. At the same time, it is also important for potential plan enrollees be informed of the benefits available to them. In writing the final rule, we ask CMS to consider options that inform enrollees about the benefits available to them, while limiting misleading messages that induce Medicare enrollees to make plan choices that they regret after enrollment.

LeadingAge, for example, reports multiple instances where individuals join Medicare Advantage plans for flex card benefits, not realizing that they will be disenrolled from the Program of All-Inclusive Care for the Elderly (PACE).[8] The New York Legal Assistance Group (NYLAG), for another example, relayed an instance in last year's commenting period where flex card advertising induced an individual to switch

Medicare Advantage plans, setting off a chain reaction that would have (without attorney intervention) related in the loss of home-and community based care and the loss of adequate personal care hours secured through prior administrative processes.[9] To provide an environment where Medicare enrollees can assess what benefits are available to them without being inundated with misleading information, Justice in Aging recommends limiting television, billboard, and radio marketing that mentions debit card amounts while allowing plans to include debit card dollar amounts in plan materials. Such information should be accompanied by language explaining the limited use for debit cards.

H. Eligibility for Supplemental Benefits for the Chronically Ill (SSBCI) and Technical Changes to the Definition of Chronically Ill Enrollee (§422.102)

Justice in Aging strongly supports CMS's proposal to require Medicare Advantage plans to list their objective eligibility criteria for Supplemental Benefits for the Chronically Ill (SSBCI) on a public facing website. Access to services, including supplemental services, ranks high on the list of Medicare enrollee priorities when making Medicare Advantage enrollment choices.[10] And yet, we hear about individuals who were surprised by restrictive SSBCI eligibility criteria after enrolling in plans, compared to what they heard in plan advertising. A healthy Medicare Advantage marketplace requires adequate information available to consumers, including SSBCI eligibility criteria. Medicare enrollees should be given full information about the benefits available to them – including scenarios where advertised benefits would be restricted.

Clear SSBCI eligibility information does not appear to be consistently. Justice in Aging surveyed a number of Evidence of Coverage documents from different Medicare Advantage plans in different states, and found limited and unclear information on SSBCI eligibility. Justice in Aging recommends that CMS provide a template and review websites to make sure SSBCI information is clear on the public-facing website. CMS should require Medicare Advantage plans to provide the website link to the SSBCI eligibility website in marketing materials and the Evidence of Coverage. One concern about SSBCI availability is geography, since Medicare Advantage plans tend to offer fewer supplemental benefits in rural areas.[11] In cases where SSBCI is limited by geography, this information should be included on the public facing website.

J. Ensuring Equitable Access to Medicare Advantage Services - Guardrails for Artificial Intelligence (§422.112)

Justice in Aging strongly supports CMS's proposal to require Medicare Advantage plans to provide services equitably, irrespective of delivery method or origin, whether human or automated. Especially for people with complex care needs, timely and appropriate coverage decisions can be a matter of life and death. Inappropriate denials have long plagued Medicare Advantage plans, and there is a growing body of evidence that artificial intelligence and other automated processes are being used to intensify the problem, further restricting care, keeping decisions away from appropriate medical professionals, and obscuring notices of denial which makes it difficult for enrollees to appeal.[12] As a result of these denials, Medicare enrollees are forced to go without appropriate medical care, post-acute care in settings like nursing facilities, substance use disorder (SUD) treatment, mental health support, and supports and services necessary to live at home. **Justice in Aging recommends that CMS goes further in preventing discriminatory action using artificial intelligence, algorithms, and other automated processes.** Final decisions should be reviewed by physicians or qualified health care professionals, and

CMS should ensure that predictive technologies do not have undue influence on human reviewers.[13] Notices of denial should include sufficient information to make an effective appeal.

K. Promoting Community-Based Services and Enhancing Transparency of In-Home Service Contractors (§422.2, 422.111)

Justice in Aging supports CMS's proposed to require a directory of supplemental service providers. Being in need of in-home or transportation services can place older adults in positions vulnerable to abuse. For example, a popular contractor providing services such as help with chores and used by Medicare Advantage plans is plagued with complaints about quality, safety, sexual harassment and assault, and theft.[14] Justice in Aging recommends that CMS continue to look at this issue, including considerations of what kind of screening requirements should be required for services rendered in people's homes.

L. Ensuring Equitable Access to Behavioral Health Benefits Through Section 1876 Cost Plan and Medicare Advantage Cost Sharing Limits (§§417.454 and 422.100)

Justice in Aging strongly supports CMS's proposal to limit behavioral cost sharing for Cost Plan and Medicare Advantage enrollees. The need for SUD and mental health treatment often comes up suddenly and acutely, and at times when money is tight. To give just one example, for people leaving jail and prison, death from overdose spikes astronomically in the first few weeks – as a devastating result of lack of access to treatment and urgent need.[15] Barriers should be as low as possible for this life-saving care. We urge CMS to make this effective January 2026.

M. Ensuring Equitable Access - Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures (§422.137)

Justice in Aging supports CMS's proposal to require disaggregated data in the annual equity report. We have heard reports of Medicare enrollees have difficulty accessing nursing facility services, post-acute care, and SUD treatment – an observation backed up by recent investigations.[16] While we recognize that disaggregating data is more administratively onerous, aggregated data can easily mask disparities in access to the most critical or costly services or services rendered less frequently.
Justice in Aging supports CMS using a mental health or SUD diagnosis as a social risk factor for this analysis. People with Mental health or substance use face a myriad of barriers to care, and face lower life expectancy – often due to lack of access to physical health care.[17]

Justice in Aging supports CMS's proposal to require Medicare Advantage plans to include an executive summary in the annual health equity report to improve transparency. Justice in Aging recommends that CMS release underlying data in a uniform format (e.g., a spreadsheet) that would allow the public access to clear, comparable data that will allow more healthy market competition based on affordable, quality care.

We echo calls by the Legal Action Center for CMS to work with Congress to apply the Mental Health Parity and Addiction Equity Act to Medicare, including Medicare Advantage and Part D plans.

N. Medicare Advantage Network Adequacy (§422.116)

Justice in Aging strongly supports CMS's proposal to evaluate network adequacy at the plan level rather than at the contract level. This change is especially important to individuals dually enrolled in Medicare and Medicaid. A new study shows that Dual Eligible Special Needs Plan (D-SNP) networks are distinct from the general Medicare Advantage plan network 46% of the time.[18] While some studies show D-SNP networks as more generous or the same as other Medicare Advantage plans[19], providers with experience in complex care and treating dually eligible individuals are generally less likely to be in a Medicare Advantage plan (compared to Traditional Medicare).[20] Dually eligible individuals tend to live in areas of provider shortage[21], and tend to have chronic conditions[22] which heighten the importance of a strong network.

Justice in Aging also urges CMS to continue improvements to network adequacy oversight. **Justice in Aging also urges CMS to require all D-SNP providers to accept Medicaid – particularly providers responsible for delivering supplemental benefits that overlap with Medicaid benefits.** This would prevent networks on paper to not work well with Medicaid.

We support the Legal Action Center's request to include separate SUD and mental health provider (rather than aggregate) analysis of provider networks, reflecting the different delivery systems and provider availability in mental health versus SUD treatment.

O. Promoting Informed Choice—Expand Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap (§§ 422.2274 and 423.2274)

Justice in Aging supports CMS's proposed agent and broker requirements to educate enrollees about MSP, LIS, and Medigap. Enrollment in LIS is a powerful tool in promoting medication adherence and improving health care outcomes – including improving access and adherence to cancer and diabetes medications.[23] Likewise, MSP reduces financial burden on enrollees, a key barrier to health care access.[24] MSP enrollment has been linked to reductions in health care avoidance.[25] MSP under-enrollment is higher among older adults, adults with dementia, and white Medicare enrollees.[26] It is important to increase the number of opportunities for Medicare enrollees to learn about affordability programs. **Justice in Aging recommends that CMS encourage agents and brokers to refer complex questions about affordability programs to the State Health Insurance Assistance Program (SHIP) network.** The SHIP network is essential for screening for and enrolling people in Medicare affordability programs. Justice in Aging also urges CMS to work with Congress to improve funding for SHIPs.

Justice in Aging has heard reports that agents and brokers have a mobile app available to them that allows them to state they have met all the requirements of a conversation with the push of a button. **Justice in Aging recommends that CMS engage in more robust oversight that agents and brokers are meeting requirements**.

P. Format Medicare Advantage (MA) Organizations' Provider Directories for Medicare Plan Finder (§§422.111 and 422.2265)

Justice in Aging strongly supports CMS's proposal to require Medicare Advantage plans to attest to the accuracy of their provider directory information. In 2022, the Government Accountability Office

found a large prevalence of these "ghost networks" – providers listed in directories who are not actually enrolled in the Medicare Advantage plan.[27] Access to providers ranks high among Medicare enrollees, but the ability to know which providers are available is hampered by inaccurate provider directories.[28] We advise advocates to tell clients to call their providers to make sure they are in network[29] - a workaround that would wreak havoc on health care provider front offices if adopted en masse.

Requiring attestation of accuracy is a great first step. Justice in Aging asks CMS to follow up with accountability for plans who submit incorrect directories. This could include allowing individuals who relied on a faulty directory to enroll in a new plan or return to Traditional Medicare.

Justice in Aging strongly supports CMS's efforts to build a central provider directory. This will save thousands of hours spent by Medicare enrollees and their assisters checking the networks of prospective plans. Justice in Aging requests that CMS implement useful filters (e.g., type of provider, language spoken, and areas of expertise).

In addition to these efforts to build a useable, accurate, central provider directory, Justice in Aging asks CMS to improve the functionality of Medicare Plan finder. Medicare Plan Finder currently has a button for each plan entitled, "View Provider Network Directory." Unfortunately, this button appears to rarely work. We tested the functionality of this button in June 2024. We looked at 60 plans in the Richmond Virginia area. Clicking the "View Provider Network Directory" link led to a provider directory 38% of the time (n=23 plans). After reaching the provider directory, a user still needed to choose a plan. Often, the plan names in the provider directory did not match the plan names in Medicare Plan Finder. Ultimately, clicking the "View Provider Network Directory" link led to a provider network directly where there was a matching plan name 12% of the time (n=7 plans). **While out of scope of this proposed rule, Justice in Aging asks CMS to require plans to post a functioning, direct link to the relevant provider directory, and that the name of the plan on their provider directory match the name in Medicare Plan finder (including the unique contract code)**.

U. Enhancing Rules on Internal Coverage Criteria §422.101

Justice in Aging strongly supports CMS's proposals to prohibit internal coverage criteria that does not have a clinical benefit and require an individual determination for internal coverage criteria. Access to services is a priority for Medicare enrollees.[30] In recent years, there have been growing concerns about prior authorization use in both Medicaid and Medicare managed care. Enrollment in a Medicare Advantage plan increases the chances of prior authorization by 76%.[31] Dually eligible individuals facing Medicare prior authorization can face resultant delay in Medicaid coverage, and at times have to deal with two prior authorization systems – one for Medicaid, and one for Medicare.

Prior authorization comes with delayed services (including delayed cancer treatment), increased distrust of providers, and a drain on local health care systems.[32] KFF found indications that, while D-SNP enrollees were subjected to fewer prior authorizations than other Medicare Advantage enrollees, they were subject to twice the denial rate.[33] Prior authorization is happening in many cases where it should be approved, indicated by successful appeal rates when individuals go through the process of appeal.[34] The system is structured to offer better services for people who have the resources to appeal. Even with extraordinary 90% reversal rate of 90% of Medicare Advantage prior authorization decisions at appeal, only 20% of patients and providers end up appealing. [35]

Prior authorization can impact how people who have faced discrimination interact with their health care, eroding the patient-provider relationship and creating "a fear in the patient that they cannot afford or they do not deserve the medical care dictated by physicians."[36] Prior authorization can impact safety net providers who serve marginalized populations – one study found that prior authorization activities took physicians and their staff 14 hours a week, adding financial strain to practices working in underserved communities. [37]

Justice in Aging urges CMS to further strengthen these provisions, by requiring that the individual determination be made by a qualified health care professional in a relevant field.[38]

Justice in Aging strongly supports CMS's proposal to require public website disclosure and an annual report of internal coverage criteria. Justice in Aging recommends that CMS prepare a template for this information so that it is readable, understandable, and comparable across plans.

Justice in Aging also recommends that prior authorization information in Evidence of Coverage documents be given a similar format requirement, so that it is readable, understandable, and comparable across plans. We reviewed a number of these documents, and found concerning trends around how prior authorization information was provided. Instructions were broad and vague ("this service may be subject to prior authorization") and did not walk through the prior authorization appeal process. At times, the instructions seemed worryingly vague. For example, one Evidence of Coverage document indicated in a chart that prior authorization may be required for ambulance rides, without specifying in that chart whether prior authorization was required for emergent or nonemergent rides. SHIP counselors and other assisters rely on Evidence of Coverage documents to provide information about plan choice. Justice in Aging asks for clearer descriptions of prior authorization in the Evidence of Coverage document, along with a link to internal coverage criteria website proposed by this rule.

Justice in Aging also asks CMS to consider the timing of prior authorization decisions. We have heard reports that prior authorizations are delayed and only finalized at the very end of the applicable period, leaving enrollees mere days to set up a specialty appointment before the approved period ends. We've also heard of prior authorization periods getting shorter, even for conditions that are chronic, stable, and will need ongoing health care. Taken together, these two practices effectively lock enrollees out of care. Justice in Aging recommends standards on the timing of prior authorization and the length of time that approvals are effective.

Justice in Aging supports the recommendations of the Senate Permanent Subcommittee on Investigations for CMS to conduct targeted audits when disaggregated data shows increases in prior authorization denials.[39]

V. Clarifying Medicare Advantage Organization Determinations to Enhance Enrollee Protections in Inpatient Settings (§§422.138, 422.562, 422.566, 422.568, 422.572, 422.616, and 422.631)

Justice in Aging strongly supports CMS's proposed changes to organizational determinations to enhance enrollee protections in inpatient settings. In certain circumstances, as a result of inpatient status decisions, Medicare Advantage enrollees face higher out-of-pocket costs for hospital care and post-acute care.[40]

Justice in Aging recommends the development of educational materials for Medicare enrollees that explain the consequences of the inpatient decision. For example, information does not appear to be publicly available about which Medicare Advantage plans have selected the three-day waiver for post-acute care coverage. CMS should publicize this data.

V. Improving Experiences for Dually Eligible Enrollees

A.a. Integrating Member Identification Cards for Dually Eligible Enrollees in Certain Integrated D–SNPs

Justice in Aging supports the proposal for Applicable Integrated Plans (AIPs) to provide one identification (ID) card for a health plan. Due to the complicated nature of dual enrollment status, Justice in Aging urges CMS to monitor for issues that arise from one ID card. For example:

- Will issues arise when a person leaves one of the plans, or if there are staggered enrollment times (e.g., when a person has to enroll in a Medicaid managed care plan first in order to enroll in the Medicare managed care plan the following month)?
- Does the ID card make it clear that applies to both Medicaid and Medicare?
- Do the phone numbers on the card work for both benefits? Does that number connect the caller to a unique hotline with staff trained on dually enrolled issues?
- What information will a provider get if they are in network for Medicare but not Medicaid (and vice versa)?

Some of these concerns could be addressed with design. Justice in Aging recommends:

- Implementing enrollee and provider user testing to make sure the card design in understandable;
- Seeking feedback from enrollees and providers on how well the cards work;
- Requiring a date issued for cards (to help with timeline issues as people churn on and off Medicaid); and
- Requiring that a person's Qualified Medicare Beneficiary (QMB) status be on the card to ensure against improper billing.

A.b. Integrating Health Risk Assessments for Dually Eligible Enrollees in Certain Integrated D–SNPs Health Risk Assessments

Justice in Aging supports CMS's proposal for AIPs to conduct one annual health risk assessment (HRA) for both Medicaid and Medicare, and requiring outreach activities for HRAs. In recognition that there are Medicaid HRA requirements that would not meet the timeframe of an AIP (e.g., assessments to determine long-term services and supports (LTSS) eligibility), Justice in Aging recommends that CMS add additional clarification about how D-SNPs would operationalize this requirement.

Justice in Aging recommends that plans be held accountable for follow up from the HRA through random audits and other oversight activities. HRAs should leveraged by plans to respond quickly to enrollee needs. For example:

- If a medical, dental, mental health, SUD treatment, or LTSS need arises as part of the health risk assessment, Medicare Advantage plans should document next steps and provide the enrollee with a contact that the enrollee can have access to for addressing those needs.

If financial difficulties or access to basic needs are brought up in the HRA, Medicare Advantage plans should screen and offer application for public benefits (e.g., Supplemental Nutrition Assistance Program (SNAP), MSPs, LIS, unemployment benefits, Low Income Home Energy Assistance Program (LIHEAP), and housing assistance). These benefits can stabilize finances and improve health. For example, SNAP enrollment is associated with fewer emergency department visits, fewer hospitalizations, delayed nursing facility admission, lower mortality rates, and Medicaid savings[41], and LIS enrollment is associated with better medication adherence and faster cancer treatment initiations.[42]

- If financial difficulties are brought up in the HRA by a dually eligible person, Medicare Advantage plans should use the opportunity to double check that they are appropriately monitoring for improper billing.
- If transportation barriers are raised in the HRA, Medicare Advantage plans should inform the enrollee of how to access transportation benefits. Transportation can be an urgent barrier to care if not implemented properly. Medicare Advantage plans should have a process in place to, in real time, handle transportation delays and get individuals to appointments.

A.c. Promoting Person-Centeredness in Special Needs Plan Individualized Care Plans and Timeliness of Health Risk Assessments and Individualized Care Plans

Justice in Aging strongly support the proposed changes to individualized care plans. Care coordination is essential for dually eligible individuals navigating the health care system. Unfortunately, the research is deeply mixed as to whether D-SNPs are meaningfully improving care coordination for dually eligible individuals. When looking at the most integrated and aligned D-SNPs, MedPAC found that they did not perform better on 41 of 45 HEDIS rates, including access to care and care coordination; and they did not perform better on any CAHPS metrics, including getting care quickly, getting needed care, getting needed prescription drugs, and care coordination.[43] A recent evaluation of Washington State D-SNPs found that "integrated care models alone do not improve access, outcomes, or beneficiary experience. Consistent clear communication to beneficiaries, network alignment, care coordination, and training of community partners are critical for improving the beneficiary experience."[44] There is also mixed data on whether D-SNPs are addressing disparities. Disparities in care coordination exist in Medicare generally.[45] In a recent study, Black, Hispanic, and other dually eligible individuals of color were less likely than white dually eligible individuals to report receiving better care in a D-SNP versus other Medicare coverage.[46] Disenrollment rates suggest that managed care does not work as well for certain groups. Black, Hispanic, Asian, and Pacific Islander individuals, as well as individuals with more care needs, are more likely to disenroll from Medicare Advantage plans than white individuals.[47] Over half of Black Medicare Advantage enrollees disenrolled within five years.[48]

Person-centered, effective care coordination is possible – and many dually eligible individuals have experienced it. One evaluation of Medicare Medicaid Plans quoted dually eligible individuals describing how high-quality care coordination improved their lives:

> "Among participants who used care coordination…many said their care coordinators had helped them obtain services they needed and helped them navigate the complexities of the health care system. Participants also mentioned that their care coordinators provided information, helped resolve problems, and facilitated communication among providers. Some said their care

> coordinators helped them set and achieve goals, particularly in Washington, where participants described achieving health and quality of life goals, such as losing weight, reducing blood sugar levels, and overcoming social isolation."[49]

Specific examples given by the report provides more detail on what good quality care coordination looks like:

> "I was going to the emergency room three or four times a week for little things. Since I started working with [my care coordinator] over the last 2 years, I've been to the [emergency room] once in 2 years"
>
> "[My mother's care coordinator] has been a godsend because she has fought for everything. When I don't get an answer from the doctor's office, she's on the phone with them."
>
> "If you have a problem with falling, they pay for the unit for you to have a pendant at home so you can get help. Before, if you were having a problem, I had to try to get that for myself."
>
> "Anytime I have a question, I can call anybody… I have people that genuinely care and they are trying to help me, and you can sense that." [50]

The need for good care coordination, both through the health care system and between Medicaid and Medicare, is the reason why D-SNPs exist – to address the unique challenges of accessing effective care while enrolled in two sometimes conflicting systems.

Justice in Aging strongly supports CMS's proposal to require outreach to individuals involved in the individualized care plan (ICP) process, require completion of the ICP within a certain number of days, and require that the ICP be person-centered and based on an individual's preferences. We also applaud CMS for describing the person-centered ICP process, including goals not specific to medical diagnoses.[51] Individualized, person-centered, care coordination is the crux of integrated care – so individuals can access appropriate, effective care in a way that works for their lives. People dually eligible experience confusion and conflicting information when attempting to navigate both Medicare and Medicaid benefits. Challenges navigating these benefits result in pain points, particularly around durable medical equipment, transportation, and HCBS access. Regulatory requirements surrounding person-centered care, coupled with robust oversight to ensure their implementation, is critical to addressing these barriers.

Justice in Aging strongly urges CMS to go further in ensuring quality person-centered care coordination is available to D-SNP enrollees. D-SNP members should have access to quality, person-centered care coordination, where care managers assist people in answering questions, navigating care challenges, and facilitating access to benefits and supports reflective of people's needs, goals, and quality of life objectives.

Enrollees should be invited in to the individualized care plan process and invited to take an active role it its development. **Justice in Aging recommends that CMS align person-centered language with the Access rule requirement that "[t]he individual, or if applicable, the individual and the individual's authorized representative, will *lead* the person-centered planning process."**[52]

Enrollees should have a say in how the individualized care plan is constructed and implemented. **Justice in Aging recommends that Medicare Advantage plans be required to timely provide enrollees a copy of their individualized care plan and provided meaningful opportunities to amend it.**

Enrollees should know what is available to them under care coordination. **Justice in Aging recommends that enrollees receive plain language about what care coordination is available to them, who their care coordinator is, how they can change care coordinators, and how they can file a grievance related to their care coordination.**

Enrollees should know who their care manager is and how to contact them. **Justice in Aging recommends that enrollees receive plain language about what care coordination is available to them, who their care coordinator is, how they can change care coordinators, and how they can file a grievance related to their care coordination.**

Enrollees should have access to care coordination that effectively solves their care access issues. **Justice in Aging recommends that Medicare Advantage plans be required to ensure that care managers possess core competencies responsive to the needs of people dually eligible, such as knowledge of community integration, person-centered planning, culturally competent and trauma informed care delivery practices, Medicaid home- and community-based services (HCBS) and Medicare home health benefits, health-related social needs, dignity of risk, and health equity.**

Enrollees should be assured that their care team be notified when they are admitted to a hospital or skilled nursing facility. **Plans should be monitored for how well they implement notification requirements when an at-risk enrollee experiences a care transition.**

Oversight is essential to whether D-SNPs are implementing the ICP process according to person-centered requirements, including:

- Random audits to verify if individualized care plans reflect the individual's care objectives as opposed to using standardized template language.
- Analysis and action based on grievance data specific to the person-centered planning processes.
- Structured opportunities for beneficiaries to provide feedback on person-centered care planning requirements, including their ability to actively lead the drafting process, make changes to their care plans, and have care plans reflect their needs and goals.
- Quality measures, designed and selected with input from beneficiaries, that meaningful measure the person-centered nature of care plans and overall care. Quality measures should prioritize the individual's satisfaction with their care needs, goals, community integration, and overall quality of life.
- Publication of the outcomes of person-centered planning process, including audits, recipient feedback, and quality measures
- Corrective action plans for Medicare Advantage plans who do not meet requirements

With additional requirements and oversight, dually eligible individuals could have better access to quality care that meets their needs.

Chronic Condition Special Needs Plans (C-SNPs)

Justice in Aging would like to raise an issue that has come up in a number of contexts. Past regulatory action has been taken to address D-SNP "look-alikes," to make sure that Medicare Advantage plans that serve a large number of dually eligible individuals are required to follow D-SNP rules designed to serve dually eligible individuals. Specifically, the regulation at 42 C.F.R. § 422.514(d)(1) restricts the percentage of dually eligible enrollment plans that are not special needs plans (D-SNPs, Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs)).

Justice in Aging is concerned that C-SNPS are being used to get around look-alike requirements. C-SNPs are not subject to the limits on the percentage of enrollees who are dually eligible; and the same time, C-SNPs are not subject to rules designed to better serve dually eligible individuals. We see C-SNPs that feature very high amounts in cost-sharing. This discourages most enrollees, except QMB enrollees and full-benefit dually eligible individuals (for whom the state covers cost-sharing). While outside of the scope of the proposed rule, Justice in Aging recommends that CMS study how C-SNPs are being used to attract dually eligible enrollees without fully serving the unique needs of that population and consider expanding look-alike regulations to include C-SNPs.

A.e. Assuring Enrollee Advisory Committee Input on Model of Care (MOC) Updates

Justice in Aging supports CMS's proposal to set Models of Care (MOC) as a discussion topic for the Enrollee Advisory Committee. The MOC is where the plans outline how they will operationalize how they ensure access to services and care. Yet, because this material is considered proprietary and private, members of the advisory committee have no meaningful way to inform the MOC. Justice in Aging recommends that the Enrollee Advisory Committee be given access to elements of the MOC in order to facilitate the discussion. For example, CMS could share:

- How the plan implements care transition protocols, including the process for connecting enrollees to appropriate providers, services, and community resources[53];
- How the plan identifies members with Medicaid service needs, and how the plan assists those members[54];
- Which partnerships D-SNPs have formed (e.g., Centers for independent living; Area agencies on aging; Protection and Advocacy systems; state councils on developmental disabilities; and mental health service networks).[55]

A.f. Making Model State Medicaid Agency Contracts (SMACs) Public

Justice in Aging strongly supports CMS's proposal to publicly post state Medicaid agency contracts (SMACs) to facilitate the effective administration of D-SNPs. Information found in SMACs is crucial for enrollees and their assisters to know. We often receive questions from SHIP counselors and other assisters, asking questions about D-SNP options, that are only available in SMACs. For example, SHIP counselors and other advisors have asked us:

- Whether a person is eligible to enroll in a D-SNP (e.g., individuals who are partial-benefit dual eligible enrollees; individuals who are in spend-down Medicaid; individuals with intellectual or developmental disabilities, or individuals enrolled in Medicaid HCBS waivers).
- How plans handle exclusively aligned enrollment;

- Whether a person's D-SNP would continue coverage under "deemed coverage" for a number of months after they lost Medicaid;
- What kind of care coordination and care transition assistance D-SNP enrollees should expect; and
- What cost-sharing assistance D-SNPs provide.

When the SMAC is not publicly available, we are unable to answer any of these questions. And public SMACs are rare. Last year, Justice in Aging attempted to identify public SMACs. We were only able to find 13 publicly available SMACs.

Justice in Aging understands that the contracts themselves could include proprietary information and agrees that model contracts are adequate for the purpose of letting members know about the D-SNP product. Justice in Aging asks CMS to review the elements of actual SMACs to evaluate if additional information should be made available. For example, one piece of information that is required to be in the actual contract, but is generally not available publicly elsewhere, is the name of the applicable Medicaid managed care contract that is aligned with the Medicare plan. This is essential information necessary for planning enrollment, as the aligned plan can determine whether and individual is eligible for the Integrated Special Enrollment Period, and individuals are sometimes (depending on state policy) automatically enrolled in the aligned Medicaid managed care plan following enrollment in the D-SNP under exclusively aligned enrollment policy. Justice in Aging asks that CMS publish the name of the aligned Medicaid managed care contract as specified in the SMAC. Other pieces of information that may not be made available in the model contract but would be in the executed contracts include geographic locations, Medicaid service carve-outs, specific approaches to care coordination, and cost-sharing protections – all of which are important for Medicare enrollees to understand their care.

We note that some states have separate model contracts for different situations. For example:
- California has separate model contracts for exclusively aligned enrollment;
- Virginia has a different model contract for full-benefit dually eligible individuals and partial-benefit dually eligible individuals; and
- The CMS SMAC template includes additional required information for Highly-Integrated D-SNPs (HIDEs), Fully-Integrated D-SNPs (FIDEs), and AIPs.

When separate model contracts exist, we ask that all versions of the model SMAC be posted.

Justice in Aging recommends that CMS require SMAC drafts be public and open for public comment. Public comment presents a key opportunity for stakeholders to provide input to improve D-SNP performance and enrollee experience. California, Ohio, and Nevada have engaged stakeholders in public SMAC comment processes. CMS could consider rules similar to the Medicaid 1115 Demonstration public comment process. For example, regulations could require states to:
- Actively notify the public of these opportunities via electronic mailing lists, administrative records, and targeted stakeholder outreach. States should post model contracts on their websites;
- Solicit written comments on the model SMAC and host public hearings to gather additional stakeholder input; and
- Compile public comment explain how these responses were considered in developing their model SMACs.

Conclusion

Thank you for the opportunity to comment on rule-making for Medicare Advantage enrollees. These changes are likely to improve access to quality care for Medicare enrollees, including those dually eligible for Medicare and Medicaid.

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[1] Proposed 42 C.F.R. § 423.137(d)(10)(ii) (Notice of Election Approval); Proposed 42 C.F.R. § 423.137(f)(2)(i) (Notice of Voluntary Termination); Proposed 42 C.F.R. § 423.137(f)(2)(ii)(C) (Notice of Failure to Pay); Proposed 42 C.F.R. § 423.137(f)(2)(ii)(D) (Involuntary Termination Notice).

[2] Proposed 42 C.F.R. § 423.2267(b)(45).

[3] Proposed 42 C.F.R. § 423.137(f)(2)(i) (Notice of Voluntary Termination); Proposed 42 C.F.R. § 423.137(f)(2)(ii)(C) (Notice of Failure to Pay); Proposed 42 C.F.R. § 423.137(f)(2)(ii)(D) (Involuntary Termination Notice); Proposed 42 C.F.R. § 423.137(g)(3) (Billing Statement).

[4] Proposed 42 C.F.R. § 423.137(f)(2)(ii)(C).

[5] Specifically, full-benefit dually enrolled individuals in a skilled nursing facility or receiving home- and community-based services. CMS Memo to All Part D Plan Sponsors regarding Calendar Year (CY) 2025 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS) (October 31, 2024).

[6] CMS, "Help Paying for Drug Costs."

[7] U.S. Department of Housing and Urban Development, "Frequently Asked Questions (FAQ): HUD-assisted Housing and Medicare Advantage Supplemental Benefits," (January 2025).

[8] LeadingAge, Letter to CMS regarding opportunities to strengthen Program of All-inclusive Care for the Elderly (PACE) participant protections against Medicare Advantage (MA) fraudulent and misleading marketing practices (July 25, 2024).

[9] New York Legal Assistance Group (NYLAG), comments on the November 15, 2023 CMS proposed rule Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications.

[10] KFF, "What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?," (September 2023).

[11] Zhiyou Yang et. al., "County-Level Enrollment in Medicare Advantage Plans Offering Expanded Supplemental Benefits," JAMA 7(9) (September 17, 2024); Hannah L. Crook, Aaron T. Zhao, and Robert S. Saunders, "Analysis of Medicare Advantage Plans' Supplemental Benefits and Variations by County," JAMA 4(6) June 23, 2021).

[12] See, e.g. U.S. Senate Permanent Subcommittee on Investigations Majority Staff Report, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care," (October 17, 2024) ("CVS began use artificial intelligence to reduce spending at post-acute facilities amid pressure to reduce costs in its Medicare Advantage division")("UnitedHealthcare sought to use machine learning to "flag" cases that were likely to be appealed" in order to selectively develop better case records).

[13] See, e.g., California's new Physicians Make Decisions Act (SB 1120); Senate Permanent Subcommittee on Investigations Majority Staff Report, "Refusal of Recovery: How Medicare Advantage Insurers have Denied Patients Access to Post-Acute Care," (October 2024).

[14] Priya Anand, "Assault Allegations Plague a $1.4 Billion Home Eldercare Startup, Bloomberg (May 30, 2023).

[15] Ingrid A. Binswanger et. al., Release from Prison—A high risk of death for former inmates," NEJM 356(2):157–165 (2007) (Risk of death due to overdose in the first two weeks following release was over 100 times that of the general population).
[16] U.S. Senate Permanent Subcommittee on Investigations Majority Staff Report, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care," (October 17, 2024); Legal Action Center, "Under-Diagnosed and Under-Covered: Claims Data Reveal Significant Medicare Gaps in SUD Treatment in 2020," (Oct. 2024) (In 2020, Medicare Advantage plans denied 45.3% of claims for inpatient hospital treatment with a primary diagnosis of substance use disorder, compared to 3.3% in Traditional Medicare; and they denied 10.9% of hospital outpatient treatment claims with a primary diagnosis of substance use disorder, compared to 2.2% in Traditional Medicare).
[17] Joe Kwun Nam Chan et. al., "Life Expectancy and Years of Potential Life Lost in People with Mental Disorders: Systematic Review and Meta Analysis," The Lancet 65(102294) (Nov. 2023).
[18] Grace McCormack, Rachel Wu, and Mark Meiselbach, "How Specialized are Special Needs Plans? Evidence from Provider Networks," Medical Research and Review 82(1) (November 2024).
[19] *Id.*
[20] Jung Ho Gong, Kenton J. Johnston, and David J. Meyers, "Proportion of Physicians who Treat Patients with Greater Social and Clinical Risk and Physician Inclusion in Medicare Advantage Networks," JAMA Health Forum (July 21, 2023).
[21] Wendy Y. Xu, Sheldon M. Retchin, and Peter Buerhaus, "Dual-Eligible Beneficiaries and Inadequate Access to Primary Care Providers," AJMC 27(5) (Jan. 26, 2021).
[22] KFF, "A Profile of Medicare-Medicaid Enrollees," (Jan. 31, 2023).
[23] Yi-Ting Chou et. al., "The Association Between Medicare Low-Income Subsidy and Anticancer Treatment Uptake in Advanced Lung Cancer," J Natl Cancer Inst 1;112(6):637-646 (June 2020) (LIS enrollment associated with reduced time in initiating anti-cancer medication); Stacie B. Dusetzina et. al., "Many Medicare Beneficiaries Do Not Fill High-Price Specialty Drug Prescriptions," Health Affairs 41(4) (2022) (LIS beneficiaries were nearly twice as likely to obtain prescribed medication); Alexandra Glynn, Immaculada Hernandez, and Eric T Roberts, "Consequences of Forgoing Prescription Drug Subsidies Among Medicare Beneficiaries with Diabetes," Health Serv Res. 57(5):1136-1144 (April 2022) (For Medicare beneficiaries with diabetes, those on low-income subsidy (LIS) were less likely to skip medications due to cost); Adam J. Olszewski et. al., "Subsidies for Oral Chemotherapy and Use of Immunomodulatory Drugs Among Medicare Beneficiaries with Myeloma," J Clin Oncol (2017) (older LIS beneficiaries were more likely to receive treatment than older non-LIS beneficiaries).
[24] Syama R. Patel, Dominic A. Ruggiero, and Eric T. Roberts, "Increasing Medicare Savings Program Enrollment – Improving Affordability of Care," JAMA Viewpoint (Oct. 30, 2024).
[25] Alex D. Federman, Bruce C. Vladeck, and Albert L. Siu, "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program, Health Affairs," 24(1) (Jan. / Feb. 2005).
[26] Kyle Caswell and Timothy A. Waidmann, Urban Institute, "Medicare Savings Program Enrollees and Eligible Non-Enrollees," MACPAC (June 2017); Eric T. Roberts, Brian E. McGarry, and Alexandra Glynn, "Cognition and Take-up of the Medicare Savings Programs," JAMA Intern Med. 2020;180(11):1529–1531; NCOA, "Medicare Savings Program and Part D Low-Income Subsidy Program Enrollment," (2022).

[27] GAO, "Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts," (March 2022); Senate Committee on Finance, "Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks," (May 3, 2023).
[28] KFF, "KFF Survey of Consumer Experiences with Health Insurance," (June 15, 2023); Commonwealth Fund, "What do Medicare Beneficiaries Value About their Coverage?" (Feb. 22, 2024) (Findings from the Commonwealth Fund 2024 Value of Medicare Survey); KFF, "What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?" (Sep. 20, 2023).

[29] Justice in Aging, "Dual-Eligible Special Needs Plans: Frequently Asked Questions" (June 2024).
[30] KFF, "What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?" (Sep. 20, 2023).
[31] Anna Jo Bodurtha Smith et. al., "Insurance and Racial Disparities in Prior Authorization in Gynecologic Oncology," Gynecol Oncol Rep (Apr. 2023).
[32] Fumiko Chino, Alexandra Baez, and Ivy B. Elkins, "The Patient Experience of Prior Authorization for Cancer Care," JAMA Netw Open (Oct. 18, 2023).
[33] KFF, "10 Things to Know About Medicare Advantage Dual Eligible Special Needs Plans," (Feb. 2024) (note that this finding is limited by data; KFF was only able to look at D-SNPs that did not share a contract with any other type of plan).
[34] KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021" (Feb. 2, 2023).
[35] Anna Jo Bodurtha Smith et. al., "Insurance-Mediated Disparities in Gynecologic Oncology Care," Obstet Gynecol (Feb. 2022).
[36] Association of Black Cardiologists, "Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients" (2019); Fumiko Chino, Alexandra Baez, and Ivy B. Elkins, "The Patient Experience of Prior Authorization for Cancer Care," JAMA Netw Open (Oct. 18, 2023).
[37] American College of Physicians, "Toolkit: Addressing the Administrative Burden of Prior Authorization," (Feb. 5, 2024).
[38] See, e.g., California's new Physicians Make Decisions Act (SB 1120).
[39] U.S. Senate Permanent Subcommittee on Investigations Majority Staff Report, Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care (October 17, 2024).
[40] Enrollee experience can vary, depending on the Medicare Advantage plan's benefit structure and whether the plan has opted to take the three-day observation status waiver.
[41] Seth A. Berkowitz et. al., "Supplemental Nutrition Assistance Program Participation and Health Care Use in Older Adults," Annals of Internal Medicine 174:12 (2021) (Higher enrollment by older adults in the Supplemental Nutrition Assistance Program (SNAP) is associated with fewer hospital and long-term care admissions as well as emergency room visits – and an estimated Medicaid cost-savings of $2,360 per person annually); Laura J. Samuel et. al., "Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland," Population Health Management (April 2018) (Seniors dually enrolled in both Medicaid and Medicare saw a decrease in hospitalization following receipt of Supplemental Nutrition Assistance Program (SNAP) benefits); Sarah L. Szanton et. al., Food Assistance is Associated with Decreased Nursing Home Admissions for Maryland's Dually Eligible Older Adults," (Seniors dually enrolled in both Medicaid and Medicare are less likely to need nursing facility care when enrolled in SNAP); Jennifer A. Pooler and Mithuna Srinivasan, "Association Between Supplemental Nutrition Assistance Program Participation and Cost-Related Medication Nonadherence Among Older Adults with Diabetes," JAMA Internal Medicine 179:1 (2019) (Seniors enrolled in SNAP more likely to comply with diabetes medication adherence); Mithuna Srinivasan et. al., "Cost-Related Medication Nonadherence for Older Adults Participating in SNAP, 2013–2015. American Journal of Public Health, 108(2), 224-230. doi:10.2105/ajph.2017.304176 (2018)," (Seniors on SNAP are 4.8 percent less likely to skip taking their prescribed medication due to cost. The effect is even bigger for seniors threatened by hunger, who are 9.1 percent less likely to skip taking medications due to cost when they enroll in SNAP.)

[42] See note 23, above.
[43] MedPAC, "Medicare Payment Policy: Report to Congress," (March 2024) (page 474). Of note, FIDE and HIDE SNPs performed similarly poorly on CAHPS, while CO DSNPs performed better on all CAHPS

measures. FIDE and HIDE SNPs only performed better on three HEDIS measures, while CO DSNPs did not perform better on any HEDIS measures.

[44] Alice Lind et. al., Washington State Department of Social and Health Services, "Navigating Dual Eligibility: A survey of dually enrolled Medicare and Medicaid beneficiaries," (July 2024).

[45] Laura C. Pinheiro et. al., "Racial Disparities in Preventable Adverse Events Attributed to Poor Care Coordination Reported in a National Study of Older Adults," Med. Care (2021) (Older black adults are significantly more likely than white older adults to report an adverse incident that is attributable to poor care coordination); Steven C. Martino et. al., "Rates of Disenrollment from Medicare Advantage Plans are Higher for Racial/Ethnic Minority Beneficiaries," Med. Care (May 31, 2021) (In a study of Medicare enrollees, Black and Hispanic individuals reported that (1) Their personal doctor was less likely to have their medical records and other relevant information about their care, (2) They had significantly greater difficulty getting timely follow up on test results, and (3) Help was less likely to be provided in managing their care).

[46] Eric T. Roberts and Jennifer M. Mellor, "Differences in Care Between Special Needs Plans and Other Medicare Coverage for Dual-Eligibles," Health Affairs 41(9):1238–1247 (Sep. 2022).

[47] Steven Martino et. al., "Rates of Disenrollment from Medicare Advantage Plans are Higher for Racial/Ethnic Minority Beneficiaries," Medical Care (September 2021). David J. Meyers et. al., "Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries," JAMA Intern Med (Feb. 19, 2019).

[48] David J. Meyers, Andrew M. Ryan, and Amal N. Trivedi, "Trends in Cumulative Disenrollment in the Medicare Advantage Program, 2011-2020," JAMA Health Forum (Aug. 25, 2023).

[49] RTI, "Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative," (2017).

[50] *Id.*

[51] 89 FR 99490 ("We intend for ICPs to engage and motivate enrollees by including goals that are meaningful to each enrollee. These may include goals that are not specific to a medical diagnosis, such as attending a child's graduation, pursuing higher education, or being able to attend religious services each week.").

[52] 42 C.F.R. § 441.301(c)(1)-(3).

[53] Element F of the draft, "Model of Care Requirements for Medicare Advantage Special Needs Plans," (January 3, 2025).

[54] Question 15 of the draft D-SNP Model of Care Questionnaire, found in Attachment B of the draft, "Model of Care Requirements for Medicare Advantage Special Needs Plans," (January 3, 2025).

[55] Question 10 of the draft D-SNP Model of Care Questionnaire, found in Attachment B of the draft, " Model of Care Requirements for Medicare Advantage Special Needs Plans," (January 3, 2025).