



March 3, 2017

Cynthia Tudor, Acting Director  
Center for Medicare  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Submitted via: [AdvanceNotice2018@cms.hhs.gov](mailto:AdvanceNotice2018@cms.hhs.gov)

**Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter (2018 Advance Notice and Call Letter)**

Dear Ms. Tudor:

Community Catalyst is pleased to submit comments to the CMS 2018 Advance Notice and Call Letter. We focus our comments primarily on sections in the draft Call Letter which 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 I: Parts C and D**

***Enhancements to the 2018 Star Ratings and Beyond***

We appreciate the importance that CMS has placed on improving the quality of care and the health outcomes of Medicare beneficiaries through enhancements in the star ratings. We urge CMS to consider measures that go beyond administrative and encounter data to include beneficiary-reported outcomes and experiences. While process measures may reduce provider burden, CMS must go further in order to capture meaningful data that articulates patients' perspectives on their care experiences, with the ultimate goal of improving health outcomes.

Measures should be constructed to track consumer quality of life, relevance to consumer goals, and transitions from institutions to integration in the community. Measures should also be framed in ways that address health disparities. These types of measures are especially important for dually eligible individuals, as they interact with the health care system more often and use social supports in the community more frequently.

As stated in the Next Steps section, we urge CMS to use the findings from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) [report to Congress](#) on the effect of social risk factors on health outcomes of Medicare beneficiaries, including those who are dually eligible for Medicaid, in development of future measures.

### ***Forecasting to 2019 and Beyond***

In thinking about measures for 2019 and beyond, we urge CMS to increase the engagement of stakeholders and consumers in measure development and selection. We urge CMS to review Community Catalyst's [recommendations](#) on engaging consumers in quality measures. Below are comments on specific measures CMS is considering for the future.

#### Potential new measures for 2019 and beyond:

##### *Care Coordination Measures*

We appreciate CMS's focus on care coordination; effective care coordination is critical to seeing improved health outcomes, especially for Medicare beneficiaries with multiple chronic conditions. We are pleased to see that CMS is conducting targeted research to identify new care coordination measures and we urge CMS to make their findings available to the public.

We understand that CMS is considering measures focused on either subgroups of Medicare Advantage (MA) enrollees or all MA enrollees. From our perspective, both approaches are needed. Some subgroup populations, like those enrolled in Special Needs Plans (SNPs), such as the dually eligible population, have more complex care needs, versus the overall universe of MA enrollees. Care coordination may look different for this population than the overall MA-enrolled population, requiring a subset of quality measures to evaluate how well MA plans are executing effective coordinated care.

We are pleased to see the proposed list of care coordination activities being considered. In addition to the ones listed, we would urge the addition of a requirement for culturally competent care. For example, the care team that is assembled for a beneficiary should have providers who understand and meet that consumer's cultural needs and preferences.

##### *Transitions of Care*

We note that in this provision there is no requirement for patient involvement in discharge planning. We strongly urge CMS to add indicators that state clearly the patient and his or her family are central to the discharge planning process and that linguistic and cultural needs are discussed and written into the patient's discharge care plan.

##### *Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions*

Special attention to follow-up care after a visit to the emergency department (ED) is critical for patients with multiple chronic conditions. As NCQA evaluates this measure, we urge NCQA and CMS to stipulate that follow-up care should be customized to the unique needs of the beneficiary. At a minimum, the timeframe for follow-up care should be no later than seven days post ED visit.

### *Alcohol Screening and Follow-Up*

We urge CMS to include this measure for the earliest possible implementation, with the goal of achieving universal screening of all patients 18 and older for alcohol misuse and providing brief counseling, when indicated based upon screening. As you will note, this measure is endorsed by the US Preventive Services Task Force and has been proven effective. We would also urge you to consider the addition of screening and brief counseling for drug misuse as a companion measure.

### *Innovation in Health Plan Design*

We appreciate the update about CMS's development of new and innovative models. We urge CMS to engage consumers and their advocates in the planning and decision-making process. In order for any innovative model to be successful, the consumers it will serve must be given a seat at the table.

## **Section II: Part C**

### *SNP-Specific Networks*

We urge CMS to ensure the 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.

### *Decreasing Health Disparities in the Quality of Care that Vulnerable Populations Receive*

We appreciate the priority that CMS has placed on addressing health disparities. We suggest the following to further CMS efforts toward eliminating disparities:

- Require Medicare Advantage Organizations (MAOs) to train their staff and providers on CMS priorities related to disparities, enforcing provisions in the current law with regard to discrimination. We strongly urge CMS to offer a webinar series on topics related to reducing disparities, on such topics as delivering culturally competent care, language access, data collection, and ADA compliance (which we know CMS already does), to name a few. We would be happy to explore this with CMS and work together to bring these important topics to the provider and plan community.
- We are excited to see that CMS expects MAOs to analyze enrollee data to identify disparities and undertake quality improvement and outreach activities. It is great to see that data is stratified by race and ethnicity. We urge that CMS go further and also stratify by language, age, gender, sexual orientation and disability status.

- We seek clarification as to how this priority fits in with the [CMS Equity Plan for Improving Quality in Medicare](#) that was released in 2015 by the CMS Office of Minority Health. We urge CMS to review [Community Catalyst comments](#) to the Equity Plan for further recommendations.

#### **Section IV: Medicare-Medicaid Plans (MMPs)**

##### ***Network Adequacy Determinations***

As CMS makes network adequacy determinations for the MMPs, we urge that focus be given to ensuring that network providers are diverse. Beneficiaries should 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. Finally, we appreciate CMS's ongoing efforts to ensure ADA competency among MMPs and providers through the Disability-Competent Care webinar series. We hope to see more providers in network with ADA compliance, competency and capacity. We hope that the forthcoming MMP performance data will include information on how well plans are doing with ADA compliance and building their capacity to serve people with disabilities. Also, as stated above, we urge CMS to strongly consider a webinar series for MMPs and other providers and provider organizations serving the dually eligible population on topics related to cultural competency.

##### ***Past Performance Information and Eligibility for Passive and Opt-in Enrollment***

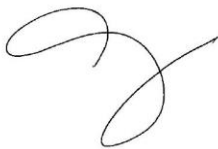
As we stated in our comments to the 2017 Medicare-Medicaid Plan (MMP) Enrollment and Disenrollment Guidance, we strongly urge CMS to consider the lessons learned from the past few years of the demonstration, namely: (1) building capacity and competency takes time; (2) it is important to consider how MMPs can address barriers such as lack of linguistic and cultural competency; and (3) staff training is critical to ensuring appropriate and timely delivery of care (particular around care coordination). We urge CMS to not allow MMPs any exceptions to passively enroll members if a plan's past performance is in question. .

In addition, we believe that passive enrollment undermines beneficiary choice and is not necessary to meet the goals of the demonstration. If passive enrollment were still to be allowed to move forward, it is imperative that outreach and education to both beneficiaries and providers remain ongoing, that continuity of care be honored, and that there is regular monitoring of the MMP's capacity to manage enrollment.

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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](mailto:ahwang@communitycatalyst.org) with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,



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