

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

February 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-4201-P
7500 Security Boulevard
Baltimore, MD 21244

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

Re: CMS-4201-P; Docket No. CMS-2022-0191; RIN 0938-AU96

Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Justice in Aging appreciates the opportunity to comment on the December 27, 2022, Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (NPRM), noted above.¹

Justice in Aging uses 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 Medicaid and Medicare, with a focus on long-term services and supports (LTSS) and the particular needs of those dually eligible for Medicare and Medicaid coverage. Our advocacy focuses on populations of older adults who have historically faced discrimination, including women, LGBTQ people, people of color, people who have limited English proficiency (LEP), and people with disabilities. Therefore, ensuring that programs and services fully and fairly serve these communities in an equitable manner is at the heart of our work.

We advocate for culturally competent, person-centered care in programs like Medicare and Medicaid to meet the diverse needs of seniors with limited incomes and resources across the country. Every day, we work with a network of advocates and professionals serving older adults who benefit from the programs at issue in this rulemaking, yet are also harmed by the unfair and inequitable practices that these proposed rules aim to remedy.

We are pleased to offer strong support for the proposed changes set forth in this NPRM. Our comments focus on aspects of the NPRM that are particularly important to the direct interface between these programs and low-income older adults, and we offer several recommendations to further the rule's goal of fair and equitable access to Medicare and Medicaid programs.

¹ Notice of Proposed Rulemaking (NPRM), "Medicare Program; Contract Year 2024 Policy and Technical Changes, *et al.*," 87 Fed. Reg. 79,452, *et seq.* (Dec. 27, 2022).



II.A. Applying D-SNP Look-Alike Requirements to Plan Benefit Package Segments (§§ 422.503(e), 422.504, 422.510 and 422.514)

We generally support the implementation of the proposed rules to address loopholes that were used to thwart the goal of the look-alike regulations.² Learning of these loopholes, however, reinforced concerns we have long had with the overly complex nature of Medicare Advantage (MA) contracting and the opportunities that complexity brings for abuse, which gave rise for the need for look-alike regulations in the first place. Complexity significantly hampers transparency as shown by the issues that plan segments have presented. With Medicare Advantage now providing health care to more than half of Medicare beneficiaries, we urge CMS to continue to take a hard look at its contracting and oversight of MA plans so that the system is more straightforward and accountable and more transparent to regulators themselves, as well as to stakeholders and researchers.

II.D. Transitional Coverage and Retroactive Medicare Part D Coverage for Certain Low-Income Beneficiaries through the Limited Income Newly Eligible Transition (LI NET) Program (§§ 423.2500-423.2536)

We strongly support the proposed rules to implement the provisions of the Consolidated Appropriations Act of 2021 that make the LI NET Program permanent.³ In particular, **we support CMS's proposal in § 423.2504(a)(2) to grant immediate access to covered Part D drugs at the point-of-sale for individuals whose eligibility as defined at § 423.773 cannot be confirmed at the point-of-sale.⁴ We further support the proposal to align the 2 months of enrollment with the ability to fill prescriptions for these immediate need beneficiaries.⁵**

It is not uncommon for long-time Medicaid beneficiaries who transition to Medicare at age 65 to be unaware of their eligibility for Medicare Part D and/or for a Medicare Savings Program (MSP), or Low-Income Subsidy (LIS)—or for states to not properly screen and transition people to MSPs and LIS. It is not uncommon for such individuals to present a prescription at their pharmacy for a medication they have been taking for some time, only to be told by the pharmacy that they will now have to pay a prohibitively high out-of-pocket cost for that medication—often a medication they must take on a regular basis. The LI-NET Program has been an incalculably valuable ally for individuals such as these, and their advocates, precisely because LI-NET covers prescriptions for such immediate needs when individuals are just at the start of applying (or re-applying) for Medicaid, or an MSP, or LIS, and therefore do not yet have proof of enrollment.

As a result, many such enrollees have been able to continue life-sustaining medication treatment for conditions such as diabetes and HIV for which continuity of treatment is critical. As CMS points out, the vast majority of such individuals are ultimately able to provide proof of eligibility for LIS once their applications for Medicaid/MSP/LIS have been processed and approved. As a result, providing immediate access to medication even for those whose eligibility cannot be immediately confirmed furthers the program goal of continuity of care during the transition to Medicare.

² See NPRM, 87 Fed. Reg. at 79,465.

³ See NPRM, 87 Fed. Reg. at 79,469 et seq.

⁴ NPRM, 87 Fed. Reg. at 79,471.

⁵ *Id.*

III.A. Health Equity in Medicare Advantage (MA) (§§ 422.111, 422.112, and 422.152)

Justice in Aging strongly supports the proposed regulatory updates in the MA program related to health equity.⁶ In particular, we support the amendment to § 422.112(a)(8) to list more examples of underserved populations to whom an MA organization must ensure that services are provided in a culturally competent manner and promote equitable access to services in order to satisfy the existing requirement, including:

- (i) “people with limited English proficiency or reading skills;
- (ii) “people of ethnic, cultural, racial, or religious minorities;
- (iii) “people with disabilities;
- (iv) “people who identify as lesbian, gay, bisexual, or other diverse sexual orientations;
- (v) “people who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex;
- (vi) “people who live in rural areas and other areas with high levels of deprivation; and
- (vii) “people otherwise adversely affected by persistent poverty or inequality.”⁷

We particularly note and support the fact that the CMS listing of LGBTQ populations is specific and inclusive. This assists in enforcement of the Affordable Care Act section 1557 prohibition against discrimination on the basis of sex, and is consistent with CMS’s pending new 1557 regulations to that effect.

Recent studies by SAGE and the Williams Institute reported that “[o]lder lesbians, bisexuals, and gay men have higher prevalence of mental health problems, disability and disease, and physical limitations than older heterosexual people.”⁸ “Transgender older adults are also at significantly higher risk for poor physical health, disability, and depressive symptoms.”⁹ HIV-positive LGBT older adults have “worse overall mental and physical health, disability and poorer health outcomes, and a higher likelihood of experiencing stressors and barriers to care . . . compared with HIV-negative LGBT older adults.”¹⁰

Yet, complicating their health care, older LGBT individuals report needing to conceal sexual and gender identity from health providers and social service professionals for fear of discrimination.¹¹ As an example of the intersectional dilemmas this community can face, a 70-year-old black transgender woman on Medicare may fear experiencing discrimination or misunderstanding from MA insurance representatives because of her transgender status, and may alternatively experience discrimination or misunderstanding because she is black. Because the LGBTQ community faces unique forms of discrimination that can have an adverse effect on their health treatment, CMS should continue to include them in the final form of this rule.

⁶ See NPRM, 87 Fed. Reg. at 79,479.

⁷ NPRM, 87 Fed. Reg. at 79,480.

⁸ Marilynn Larkin, “Enhancing Health, Wellness and Community for Older LGBT Adults,” *The Journal on Active Aging* at 38 (July/August 2018) (citing and quoting Choi, S. K., & Meyer, I. H., “LGBT Aging: A Review of Research Findings, Needs, and Policy Implications,” *The Williams Institute, University of California, Los Angeles Law School* (2016)), available at www.lgbtagingcenter.org/resources/pdfs/Enhancing%20health-LGBT-low%20res.pdf.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

III.A.3. Requirement that organizations must include providers' cultural and linguistic capabilities in their provider directories (§ 422.111(b)(3)(i))

Justice in Aging supports CMS's proposed new requirement at § 422.111(b)(3)(i) that organizations must include providers' cultural and linguistic capabilities in their provider directories.¹² We are concerned, however, that providers will either under-report or over-report their capabilities.

It is our understanding that it is generally difficult for plans to get providers to report information about themselves for plan directories and that directories are frequently out of date. In addition, the rule as stated does not give either plans or providers sufficient guidance on how to determine a given provider's capabilities. For example, is the ability to engage in conversational Spanish sufficient for a health care provider to report Spanish as a "linguistic capability," or do they need some higher and more specific level of fluency? With respect to staff, while we note that the NPRM references a Medicaid regulation using the term "skilled medical interpreter," we expect that many providers are unfamiliar with the generally accepted standards for that designation. There is a similar need for clarity with respect to what constitutes disability access. **Plans and providers will need additional guidance on the standard to be applied in responding to this reporting requirement.**

Oversight, including secret shopper surveys, also is necessary to monitor the accuracy of provider directories more generally and, more specifically, the language and disability access information to be collected under this rule. The track record of provider directories in giving accurate and current information has been dismal and unlikely to improve significantly without strong monitoring by CMS.¹³

III.A.4. Digital Health Education for Medicare Advantage Enrollees Using Telehealth (§ 422.112(b))

We commend CMS for recognizing the challenge many older adults face in accessing health care through digital means. **We support CMS's proposed addition to § 422.112(b) to require that MA organizations "develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy."**¹⁴ We regularly hear from our grassroots partners that older adults—and especially those with low income—struggle with accessing their health care providers through digital means. Many of those most challenged also have limited proficiency in English and it is important that outreach by plans specifically include LEP members. Such assistance will further the goal of health equity for older adults.

We note that CMS is also proposing to require MA organizations to make information about these programs available to CMS, but only from a sampling of about nine MA organizations a year, "upon request."¹⁵ As CMS notes, however, "we have no way of knowing or estimating the extent of low digital health literacy specifically among MA organizations' enrollees,"¹⁶ nor likely does anyone else. Such information would be very helpful not only to MA plans and CMS, but also to allied organizations that seek to improve digital health literacy among older adults. As a result, **CMS "should require regular**

¹² NPRM, 87 Fed. Reg. at 79,482.

¹³ CMS, *Online Provider Directory Review Report* (November 28, 2018), available at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf

¹⁴ NPRM, 87 Fed. Reg. at 79,484.

¹⁵ NPRM, 87 Fed. Reg. at 79,485 (citing proposed § 422.112(b)(9)(i)); 79,486.

¹⁶ NPRM, 87 Fed. Reg. at 79,486.

reporting of data of this type from all MA organizations alongside other Part C reporting requirements,”¹⁷ and make that data available to the public.

III.A.5. Quality Improvement Program (§ 422.152(a)(5))

We strongly support CMS’s proposal at § 422.152(a)(5) to require MA organizations to incorporate into their overall QI program activities that reduce health disparities.¹⁸ Such program activities would require sufficient data collection to determine whether equity goals are successfully being addressed. **We also urge additional transparency with respect to QI programs.** For example, Special Needs Plans (SNPs) are required to submit to CMS for approval a “model of care (MOC), which serves as the framework for meeting the individual needs of SNP enrollees, and the infrastructure to promote care management and care coordination.”¹⁹ The SNP is then required to implement the approved model of care. Yet SNP MOCs are not generally publicly available and the determination of whether a plan successfully implemented its model is not incorporated in any transparent way to assessments of plan quality such as star ratings. Nor is there an opportunity for stakeholders such as D-SNP enrollee advisory committees to weigh in on the appropriateness of the plan’s MOC or the plan’s performance in implementation.

III.C. Medicare Advantage (MA) Network Adequacy: Access to Services (§ 422.112)

We strongly support the proposed rules regarding network adequacy, especially to maintain “in-network cost sharing when the MA organization arranges for the benefit outside of the network.”²⁰ This provision is very important for individuals with rare conditions, e.g., neurological disorders, and for conditions, such as gender dysphoria, for which the pool of experienced treatment providers is small. It is also important for enrollees who live in rural areas of limited service.

Current network adequacy rules set standards for relatively broad specialty areas but do not (and often cannot) account for all levels of sub-specialization, particularly sub-specialties that may be important for particular marginalized subgroups. While some gaps are inevitable, those gaps should be met by liberal opportunities to use out of network providers.

We hear from advocates that this is not always the case. For example, the universe of surgeons experienced in certain complex gender-affirming surgeries is relatively small and many do not belong to plan networks. However, advocates have reported instances where plan members were denied opportunities to use out of network providers and, instead, were steered by their plans to significantly less experienced providers who were in the plan’s network. These issues have arisen as well for people with complex disabilities. Another current example is the limited specialists who treat long-COVID and other post-viral conditions. As the public health emergency ends, including temporary requirements on MA plans to cover out-of-network providers,²¹ it is important for MA enrollees to have access to these specialists.

We urge CMS to, at least, track appeals of requests for out-of-network providers with the goal of identifying if plan denials create inequities.

¹⁷ *Id.* (emphasis added).

¹⁸ See NPRM, 87 Fed. Reg. at 79,488.

¹⁹ NPRM, 87 Fed. Reg. at 79,487.

²⁰ NPRM, 87 Fed. Reg. at 79,493

²¹ 42 C.F.R. § 422.100(m)

III.D. Re Provider Contract Termination Rules (§§ 422.111 and 422.2267): CMS should adopt a separate, new Special Enrollment Period (SEP) for when a provider contract is terminated.

We support the proposed improved notice rules concerning provider contract terminations.²² With respect to the content of the required written notification, we ask that, besides providing information about the Annual Coordinated Election Period (AEP) and the MA Open Enrollment Period (MA-OEP) in the notices, plans should also be required to provide information about the availability of a Special Enrollment Period for affected individuals with the Low-Income Subsidy and/or Medicaid.

Notice alone, however, is insufficient to protect plan members from harm. CMS needs to address the source of the problem by prohibiting MA plans from terminating network providers mid-year without cause. Enrollees choose plans based on information provided at the start of the plan year. They largely are stuck with their choice while plans are virtually unfettered in changing the element on which beneficiaries most rely, continued access to providers with whom they have developed a relationship of trust. Loss of a trusted provider causes anxiety and worry for all beneficiaries and, as CMS has noted, can be particularly traumatic in the case of behavioral health providers. CMS should not allow plans to drop providers simply because the plan has decided to do so for its own business reasons.

In response to CMS's request for comments on SEP relief for individuals losing providers, we agree with CMS that, at the very least, an Extraordinary Circumstances SEP should be available when an enrollee loses access to a provider but, as a more appropriate solution, **we recommend that CMS adopt a separate, new SEP for enrollees whose provider contract has been terminated.**²³ A separate SEP to cover provider contract terminations would be simpler to administer and clearer for beneficiaries to navigate.

Requiring enrollees to resort to the "other exceptional conditions" SEP under § 422.62(b)(26) would require a determination based on the *individual's unique circumstances*, requiring an enrollee to make an individualized case followed by review on an *ad hoc* case-by-case basis. Yet the termination of a provider contract is not an individually "unique" circumstance. It is a circumstance common to all of the enrollees who have been patients of the provider: the promised coverage for the provider that the enrollee chose has been terminated for reasons beyond the enrollee's control.

Creating a separate SEP for this circumstance would simplify administration and be less burdensome for beneficiaries. Section 422.62(b)(26) is designed for individual, unique circumstances—not for a clearly defined and anticipated circumstance such as provider contract termination that by its nature impacts a clearly defined (and potentially large) class of enrollees.

We therefore propose that CMS adopt a new three-month SEP available to any plan member who receives a notice of provider termination sent in accordance with § 422.111. We do not believe any additional restrictions should apply. Beneficiaries alone understand which providers are important enough for them to make a change. They did not create the situation they find themselves in and they should have a simple and direct way to extricate themselves if they choose to do so.

²² See NPRM, 87 Fed. Reg. at 79,494 *et seq.*

²³ NPRM, 87 Fed. Reg. at 79,496-79,497.

III.E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, 422.138, and 422.202)

We generally support CMS’s proposed new rules to “ensure that utilization management tools are used, and associated coverage decisions are made, in ways that ensure timely and appropriate access to medically necessary care for beneficiaries enrolled in MA plans.”²⁴

The deficiencies in current utilization management as practiced by MA plans are widespread and persistent. An Office of the Inspector General report looking at 2014-16 data noted that MA plans overturned 75 percent of their own denials-- i.e., approximately 216,000 denials each year.²⁵ Further, “independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers.”²⁶ Yet during the same time period, beneficiaries and providers appealed only 1 percent of denials.²⁷ When Kaiser Family Foundation looked at the two million MA prior authorization requests that were denied in 2021 data, it found that the process continues to be seriously flawed. In the Kaiser review, of the 11 percent of denials were appealed, and of those fully 82 percent resulted in fully or partially overturning the initial denial.²⁸

These facts demonstrate that the MA prior authorization process is flawed, frequently resulting in denial of coverage for medically necessary care. Explicitly requiring MA organizations to make their coverage criteria publicly accessible will help to avoid problems beneficiaries and their providers face in understanding exactly what information is needed to support a prior authorization request. Even more importantly, the proposal begins to tackle the problem that some plans set criteria that are inconsistent with statutory requirements and deny their members access to services to which they are entitled.

In particular, we are pleased that CMS proposes, at § 422.101(b)(6), to require MA organizations to make their internal plan coverage criteria process public, “by providing a publicly accessible summary of evidence that was considered during the development of the internal coverage criteria . . . , a list of the sources of such evidence, and include an explanation of the rationale that supports the adoption of the coverage criteria used to make a medical necessity determination.”²⁹

We are concerned, however, that nowhere in proposed § 422.101(b) does CMS explicitly require the MA organization to make the internal plan coverage criteria public as well.³⁰ While the proposed rule requires that the “evidence,” “sources” and “rationale” be made publicly accessible, the rule as currently worded only *implies* that the coverage criteria must also be made public.³¹ It does not explicitly say so, however.

²⁴ NPRM, 87 Fed. Reg. at 79,498.

²⁵ U.S. Dept. of Health and Human Services, Office of the Inspector General, “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials,” OEI-09-16-00410 (Sept. 2018), available at <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>.

²⁶ *Id.*

²⁷ *Id.*

²⁸ Kaiser Family Foundation, “Medicare Advantage Plans Denied 2 Million Prior Authorization Requests in 2021, About 6% of Such Requests” (Feb. 2, 2023), available at www.kff.org/medicare/press-release/medicare-advantage-plans-denied-2-million-prior-authorization-requests-in-2021-about-6-of-such-requests/.

²⁹ NPRM, 87 Fed. Reg. at 79,501.

³⁰ See NPRM, 87 Fed. Reg. at 79,712.

³¹ *Id.*

Narrowly read, the rule could be construed to mean that plans are not obligated to make the coverage criteria itself fully accessible to the public. MA enrollees often struggle with denials of coverage because many plans do not fully disclose their criteria or the basis on which prior authorizations are denied. Many MA organizations consider these criteria proprietary and therefore entitled to secrecy. Enrollees therefore do not know how to appeal because they do not know the applicable standard.

The rule should therefore be amended to explicitly require MA organizations to make their internal plan coverage criteria publicly accessible, in addition to the bases for those criteria. Doing so will help both providers and enrollees know in advance the applicable criteria so they can prepare a request for prior authorization appropriately and thereby avoid unnecessary denial and appeal. In the event of a denial, publicly available coverage criteria will facilitate resolving an appeal at the lowest possible level.

III.F. Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)

In response to the request for comment,³² we wish to first address enrollment incentives. We believe that the problem of rewards as an inducement for enrollment is much larger than what constitutes a cash incentive. **All sign up incentives should be entirely prohibited.** We hear from advocates in the field that some MA plans offer potential enrollees narrower one-time sign-up gifts to incentivize them to join, e.g., a free at-home blood pressure monitor, or a one-time grocery store cash card. Such sign-up incentives, whether or not they meet the definition of a cash equivalent, are particularly misleading for low-income dually eligible Medicare enrollees who face ever-present economic need. Moreover, particularly because they are enrollment rewards, some might push an individual who is eligible for Medicaid above income limits for the month of receipt, leaving the beneficiary much worse off.

The decision regarding which plan to sign up for can and should be based on an evaluation of the specific health needs of the enrollee and which plan offers the most extensive coverage for the least cost. One-time enrollment incentive gifts *of any kind* are irrelevant to that analysis and unduly prejudicial.

With respect to Rewards and Incentive (R&I) programs to promote health, though we appreciate that CMS wants to ensure reasonable definitions for benefits, we primarily have other concerns. First is the deceptive marketing of these benefits, particularly in TV advertising. The fact that benefits are only available under limited circumstances and are health-related is lost in the actors' excited utterances about how much money they save. While the fine print terms of plan documents are more precise, the advertisements are what guide consumer choices.

Also, currently there is little public data on how often these benefits are provided and no demographic data on who receives them. This absence of information makes it impossible to determine how often plans are actually providing these benefits and if they are doing so equitably to their members.

Finally, in order to protect low income people with Medicare from unintended consequences from participating in R&I programs, we ask CMS to work to provide clarity on how R&I benefits would or would not affect eligibility for low income programs such as Medicaid, SNAP and SSI. Although we believe that in almost all cases, R&I benefits would be exempt from program counting because they are health related, there are some gray areas, for example, grocery cards that some D-SNPs provide to all their dual eligible members regardless of health status. We ask that CMS, in consultation with the Social

³² See NPRM, 87 Fed. Reg. at 79,508.

Security Administration and the Department of Agriculture, provide guidance so that states, beneficiaries, and plans have clear direction and so that program offerings and benefit rules align.

III.K. Call Center Interpreter Standards (§§ 422.111(h)(1)(iii)(A) and 423.128(d)(1)(iii)(A))

We strongly support CMS’s proposed regulations to establish standards for interpreter services used by MA and Part D plan toll-free customer call centers.³³ More than 6.5 million older adults have Limited English Proficiency (LEP). Given its complexity, health care information can only be communicated effectively in an individual’s primary language. Setting standards for call center interpreters is critical to ensuring access to care for older LEP enrollees.

Research shows there is widespread need for good interpretation in accessing health care. In one study looking at care transitions, researchers reported that access to language services was limited and varied significantly by race, ethnicity, and language.³⁴ More than half of patients in the study with LEP reported lacking access to medical interpreters and translated materials. With respect to disparities, “Hispanic or Latino patients and patients with limited English proficiency were less likely to report access to a computer and less likely to access the Patient Gateway portal. Black or African American patients were also less likely to use the Patient Gateway portal. Asian patients were more likely to be worried about getting home health services.”³⁵ Since MA plans are the gatekeepers to care, particularly for LEP individuals who also have limited internet competency, adopting the standards set forth in this rule is necessary for ensuring care for older LEP adults.

III.O. Updating Translation Standards for Required Materials and Content (§§ 422.2267 and 423.2267)

1. Standing Request for Translated Materials and Materials in Accessible Formats Using Auxiliary Aids and Services (§§ 422.2267 and 423.2267)

Justice in Aging also strongly supports the proposal to require plans to provide translated and accessible materials and auxiliary aids and services to enrollees on a **standing basis** rather than requiring repeated requests by plan members.³⁶ **We also support specifically applying these requirements to individualized plans of care for D-SNPs.** Individualized care plans are a core element of person-centered care. Ensuring that they are subject to translation requirements will assist both LEP members and their family caregivers, many of whom are themselves LEP as well.

We recommend, further, that CMS adopt and apply these rules to itself, i.e., establish procedures that allow LEP Medicare enrollees to make a standing order for CMS to provide translated correspondence and publications (e.g., the annual Medicare & You handbook). Currently, although CMS recently expanded the languages into which Medicare & You is translated, individuals must request translated copies repeatedly each year. Not surprisingly, this barrier has the effect of suppressing uptake of this valuable resource. Ensuring that beneficiaries consistently and automatically receive important notices and other communications about their health and insurance in their preferred language would further

³³ NPRM, 87 Fed. Reg. at 79,512 *et seq.*

³⁴ Esteban A. Barreto, *et al.*, “The Role of Race, Ethnicity, and Language in Care Transitions” (July 21, 2021), <https://www.ajmc.com/view/the-role-of-race-ethnicity-and-language-in-care-transitions>.

³⁵ *Id.*

³⁶ NPRM, 87 Fed. Reg. at 79,521, 79,697.

CMS's stated health equity priorities and should be a high priority. CMS by its own practices should be taking the lead and setting a model for plans to emulate.

Further, this standing order rule should be extended to interpreter services. If an LEP plan enrollee has requested an interpreter for live, real-time communication, e.g., over the phone or in connection with a visit to an in-network provider, the enrollee should have the option to establish a standing order for interpretation. Plans should implement the request for both incoming and outgoing calls to the enrollee and should proactively ensure that interpreters are arranged for in-network appointments. Plans should be required to note in the enrollee's record the need for interpretation and the specific language needed.

The same rule should apply to CMS itself. When requested by any LEP enrollee, CMS should as a matter of course note in the enrollee's Medicare record a standing order for interpretation and the language required, to be used for both incoming and outgoing calls.

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

We also take this opportunity to renew with CMS our longstanding request for the agency to revisit its threshold requirements for translations by MA and Part D plans. Current 42 C.F.R. § 422.2267(a)(2) and its companion regulation for Part D, 42 C.F.R. § 423.2267(a)(2), require translation of certain marketing and communications materials "into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area." **We recommend setting a more inclusive threshold that, in addition to using percentage of individuals in a PBP, also requires translation if a numerical threshold is reached. That threshold could be based either on the number of individuals speaking the non-English language in the PBP or the number enrolled in the plan.**

With very few exceptions, the 5 percent standard means that the translation requirement applies only to Spanish. Yet close to one million Medicare beneficiaries speak a non-English language other than Spanish.³⁷ Using a percentage measure without any reference to the absolute number of individuals in a service area leaves significant swaths of LEP individuals, particularly those in large diverse service areas, without access to any translated materials from their Medicare Advantage plans and leads to anomalous results. For example, both Los Angeles County and New York City have larger Chinese speaking populations than San Francisco, yet because percents alone determine translation responsibilities, MA plans in San Francisco are required to translate documents into Chinese but those in Los Angeles and New York City are not.

The inequities are even greater when looking at Part D plans that serve entire states such as California or New York where, despite having some of the largest LEP populations in the country, Part D plans are only required to translate documents into Spanish because no language group meets the 5 percent threshold.

CMS has made a commitment to promote equity in health care and address health disparities. Creating a more realistic translation threshold for Medicare is a necessary and important step toward achieving those goals.

³⁷CMS, "Understanding Communication and Language Needs of Medicare Beneficiaries," at 9 (Apr. 2017), available at www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.

2. Requirement that FIDE SNPs, HIDE SNPs, and applicable integrated plans (AIPs), translate all Medicare and Medicaid materials (§§ 422.2267 and 423.2267)

Justice in Aging strongly supports the proposal to require that FIDE SNPs, HIDE SNPs, and applicable integrated plans (AIPs) translate Medicare materials into any languages required by the Medicaid translation standard of the state in which the plan operates.³⁸ A similar requirement was successfully applied to Medicare-Medicaid plans in the Financial Alignment Initiative and resulted in improved communication to plan members. We also support the specific requirement in proposed §§ 422.2267(a)(3) and 423.2267(a)(3) to extend a similar translation requirement to individualized plans of care for special needs plans [SNPs].³⁹

Further, we urge CMS to apply this translation requirement to all D-SNPs, including those that do not have matching Medicaid managed care plans. D-SNPs are designed for and required to offer at least some coordination between Medicare and Medicaid benefits, even when Medicaid benefits are provided on a fee-for-service basis. Sending communications to a plan member about Medicare in English—a language that the individual cannot understand—when that same member is receiving information about Medicaid benefits in another language the individual can understand is the antithesis of coordination. Conforming to state translation standards should be one of the core minimum requirements for all D-SNPs.

III.P. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

We appreciate that CMS is proposing regulations to rein in the overwhelming barrage of on-air advertising, mailings, emails and texts that misrepresent MA benefits and lead individuals to make choices that do not meet their health care needs. **We strongly support the proposed improvements to MA and Part D marketing⁴⁰ and in particular adding “effect on current coverage” to the Pre-enrollment Checklist (PECL).**⁴¹ We ask that CMS flesh out this requirement to require that the plan or broker explain to individuals the plan’s limitations on which providers they can use and offer to assist the enrollee in determining whether any current provider that the individual values is in the plan’s network. Explaining the need for prior authorizations should also be particularly required.

We also urge that the checklist include a specific requirement that, if the prospective enrollee is a dual eligible, the plan or broker must provide a rudimentary explanation of whether benefits offered by the plan duplicate benefits already available to the individual through Medicaid. For dual eligibles, the issue is both what they might lose and, importantly, what they won’t gain. We hear from advocates frequently that dual eligibles who either were in Original Medicare or a D-SNP were lured into an inappropriate MA plan based on the promise of an “extra” benefit to which they were already entitled because of their Medicaid status.

We recognize that making a determination of where there are overlaps with Medicaid would be difficult for brokers who are selling a wide range of plans. We believe, however, that it is not unreasonable to require that any MA plan that operates in a state must learn enough about its state Medicaid program to know, for example, whether the state offers a dental or vision benefit and whether the state covers Part B premiums for Medicaid enrollees. It also would be misleading to offer a “no deductible” feature as a plan benefit to a Qualified Medicare Beneficiary (QMB) who has no co-insurance responsibility.

³⁸ See NPRM, 87 Fed. Reg. at 79,454, 79,523.

³⁹ *Id.*

⁴⁰ See NPRM, 87 Fed. Reg. at 79,455, 79,524 *et seq.*

⁴¹ NPRM, 87 Fed. Reg. at 79,524.

Plans could create charts or FAQs to guide brokers (they would be helpful for SHIPs as well). We recognize that there are nuances in the extent of benefits on both the MA plan and Medicaid side but brokers and plans should at least have the responsibility to flag that overlap issues may exist. We hear from our colleagues in direct service that dual eligibles often struggle to understand their options and are surprised to learn what they have lost by switching plans. Given their low income, duals are the least able of all Medicare beneficiaries to work around the loss of critical coverage.

More generally, we have concerns about over-marketing to dual eligibles. Because of their significant health needs and their economic vulnerability, they need the LIS/Medicaid SEP that allows them a change of plan each quarter. However, they do not need—and certainly do not benefit from—a spate of confusing marketing year-round just because they have a SEP during the “dry season” for brokers. We ask that CMS consider imposing limits on mid-year plan and broker outreach to this population which can be particularly vulnerable to sales pitches.

We have a specific request with respect to review of plan marketing materials. We recognize that plan marketing materials submitted to CMS for review are voluminous and expect that CMS’s ability to thoroughly review all materials is limited. We ask, however, that CMS prioritize review of marketing material submitted by MA plans that have high dual eligible enrollment but not high enough to meet the criteria for D-SNP look-alikes. During the 2023 OEP, SHIP counselors saw marketing materials from some of these plans that was highly misleading and directly targeted at dual eligibles. We brought some examples to CMS’s attention and appreciate that the agency required the plans to correct their messaging. We ask the agency to proactively review submissions from this category of plans to ensure that similar marketing does not occur during the 2024 OEP.

Finally, we note that CMS stressed throughout that it will hold plans accountable for marketing on their behalf by agents, brokers, or third-party organizations. We ask that CMS closely oversee marketing and impose meaningful sanctions so that accountability has teeth. There is a wide range of sanctions that CMS could employ. We note, for example, that in the early days of Part D, when audits found major deficiencies with Part D plans, CMS suspended the opportunity for new enrollments until plans could demonstrate that deficiencies were corrected. We have not seen those suspensions in recent years in large part because the earlier actions had the intended salutary effect. Civil Monetary Penalties are another tool but must be sufficient to be more than a mere expense of doing business.⁴² Claw-backs of broker commissions for all enrollments based on misrepresentations—even for those beneficiaries who choose not to disenroll—would also be effective.

We also urge that, when instances of misrepresentation or overreach come to CMS’s attention, CMS should require plans to send notices to all enrollees who may have been affected by the misrepresentation that they may have access to a SEP. Finally, we ask that for any enforcement action with respect to marketing, CMS make its action public and notify media, both to spread the word to affected beneficiaries and to highlight the violation.

⁴² See, e.g., CMS, 2021 Part C and Part D Program Audit and Enforcement Report (June 7, 2022), available at <https://www.cms.gov/files/document/2021-program-audit-enforcement-report.pdf>.

III.R. Medication Therapy Management (MTM) Program (§ 423.153)

Justice in Aging strongly supports the proposed amendments to the Medication Therapy Management Program at 42 C.F.R. § 423.153.⁴³ The Medication Therapy Management Program cannot accomplish its goals, however, unless it measures and addresses health disparities and inequities among its enrollees. In order to do so, **we urge CMS to further require Medicare Advantage (MA) and Part D plans to gather and report enrollee data to CMS that can be disaggregated and analyzed intersectionally by age, race, ethnicity, sex, sexual orientation and gender identity, primary language, and geographic location (e.g., urban, suburban, rural).** We also urge CMS to **make this data publicly available.**

Because the purpose of MTM programs is to “assure, with respect to targeted [at-risk] beneficiaries, that covered Part D drugs are appropriately used to optimize therapeutic outcomes,”⁴⁴ it is therefore critical to gather data specifically to measure and address inequities based on age, race, ethnicity, sex, sexual orientation and gender identity, English language proficiency, and geographic location among such at-risk beneficiaries.

Justice in Aging also supports the proposal to create a new provision at § 423.153(d)(2)(iii) “**to codify the 9 core chronic illnesses currently identified in [its] guidance and to add HIV/AIDS, for a total of 10 core chronic diseases.**”⁴⁵ Since nearly half of people living with HIV are age 50 and older, this is an important target population.⁴⁶ Moreover individuals with HIV also have a higher number of comorbidities compared with HIV-negative people, including especially cardiovascular disease, hepatic and renal disease, osteoporosis and fractures, metabolic disorders, and cancers, and their risks for those morbidities increase with age.⁴⁷

Codifying the currently identified nine core illnesses for MTM and adding HIV/AIDS will advance the program’s goal of optimizing therapeutic outcomes for the increasing number of older adults living with long-term HIV.

III.V. Limitation on PDP Contracts Held by Subsidiaries of the Same Parent (§ 423.272)

We strongly support the proposal to limit the number of PDP contracts under which a Part D sponsor or its parent organization directly or through subsidiaries, can offer individual market PBPs in a PDP region to one contract per region.⁴⁸ We agree that for Part D enrollees to have meaningful options, there must be meaningful competition among options. Beneficiaries in most regions currently face far too many plan choices, both with Part D plans and MA plans. The proposed regulations are a step in improving the opportunity for meaningful choice. More is needed, particularly on the MA plan side. Having too many choices is really no choice at all. We urge CMS to consider some of the standardization of plan benefits, limitations on issuer plan offerings and other elements adopted in the Marketplace as a way to move in the right direction.

⁴³ 87 Fed. Reg. 79,452, 79,453, 79,542 *et seq.*

⁴⁴ NPRM, 87 Fed. Reg. at 79,542 (*citing* § 1860D-4(c) of the Social Security Act, 42 U.S.C. § 1395w-104(c) (current through Aug. 16, 2022)).

⁴⁵ NPRM, 87 Fed. Reg. at 79,544.

⁴⁶ NIH, National Institute on Aging, “HIV, AIDS, and Older Adults” (Sept. 2021), *available at* <https://www.nia.nih.gov/health/hiv-aids-and-older-adults>.

⁴⁷ *Id.*

⁴⁸ See NPRM, 87 Fed. Reg. at 79,557.

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies

B. Defining Institutional Special Needs Plans and Codifying Beneficiary Protections (§ 422.2)⁴⁹

We urge CMS to take a deep and hard look at I-SNPs and the extent to which they are serving the needs of their members who are overwhelmingly dual eligibles. A particular concern we have is whether I-SNPs are taking adequate steps to assist their members who wish to return to the community. That issue comes into sharpest focus for the growing number of I-SNPs that are owned by skilled nursing facility providers who have no incentive to create empty the beds in their own facilities.

We believe that more regulation of I-SNPs is required and more information is needed, including more review of key indicators on how I-SNPs and D-SNPs compare when serving similarly placed dual eligibles.

IV.O. Possible End Dates for the SEP for Government Entity-Declared Disaster or Other Emergency (§§ 422.62 and 423.38)

We recommend that CMS set the time period for the SEP for Government Entity-Declared Disaster or Other Emergency end six full calendar months following the end date identified in the declaration— rather than the 2 full calendar months proposed—in order to align this rule with the time periods provided for the Medicare Part A and Part B enrollment SEP under the Consolidated Appropriations Act (CAA).⁵⁰ In the case of a disaster declared by federal, state, or local government, the Part A and Part B SEPs start on the first official day of the emergency or disaster and last until six months after it officially ends.

We are concerned that two-month end date for the MA and Part D SEPs would disqualify for individuals who enroll in Medicare during the last four months of the Medicare SEPs from the opportunity to enroll in a MA or Part D plan. We ask CMS to modify the language of Sections 422.62 and 423.38 so that there is clarity that all individuals using the Medicare SEPs would be able to enroll in an MA or Part D plan. We also ask for a six-month length to these SEPs simply because of the confusion that would result for beneficiaries and their advocates who are looking at regulations with two different timeframes. Moreover, as CMS recognized in deciding on the six-month timeframe for the Medicare SEP, individuals recovering from a disaster face a host of challenges, of which Medicare enrollment is only one. A six month period after the end of the declared disaster better responds to the realities these individuals face.

IV.U. Shortages of Formulary Drug Products During a Plan Year (§ 423.120)

We generally support the provisions regarding shortages of formulary drug products under Part D plans.⁵¹ **We object, however, to the proposed rule regarding enrollee cost sharing for a substituted, non-formulary drug.** CMS has proposed that, if an enrollee's Part D plan is experiencing a shortage of a drug prescribed for the enrollee and must substitute an "alternative product [that] is non-formulary, then the enrollee would be expected to pay the cost sharing associated with formulary exceptions."⁵² Forcing the enrollee to pay a higher out-of-pocket cost because of a shortage beyond the enrollee's

⁴⁹ See NPRM, 87 Fed. Reg. at 79,566.

⁵⁰ See 42 U.S.C. § 1395p(m); 42 C.F.R. §§ 406.27(b); 407.23(b).

⁵¹ NPRM, 87 Fed. Reg. at 79,588.

⁵² NPRM, 87 Fed. Reg. at 79,589.

control is unfair, threatens to undermine treatment, and deprives the enrollee of the benefit of the bargain with the Part D plan.

Of all the stakeholders in a drug shortage scenario—the manufacturer, insurance company, pharmacy, and the enrollee—the enrollee has the least control over a drug shortage and, especially in the case of a low-income older adult, has the least ability to absorb the cost of a higher-priced substitute. All of the other players in such a scenario have the professional and institutional ability to foresee shortages far better than an enrollee, and have far deeper pockets than the vast majority of enrollees to absorb costs of a higher-priced substitute drug. It is unfair for this rule to put the added cost of the shortage on the enrollee.

The proposed rule could also have significant and disproportionate impact on beneficiary health. Having to pay for a higher-priced substitute will cause many near-poor and low-income individuals to simply stop taking any medication for the condition under treatment. This will result in worse health outcomes and disproportionately affect Black and Hispanic enrollees, who tend to be lower income than white beneficiaries.

CMS should therefore amend the proposed new paragraph (g)(2), to say the reverse, i.e., to specify that the Part D sponsor shall be required to charge the cost sharing that applies to the unavailable formulary product for the alternative product whether the alternative is on formulary or not, and may not charge the applicable sharing that would apply to the alternative therapeutically equivalent or interchangeable product's formulary status and the plan benefit design.

AD. Crosswalk Requirements for Prescription Drug Plans (§ 423.530)

We generally support the proposed crosswalk requirements for prescription drug plans.⁵³ In response to CMS's expressed interest in learning "how best to balance avoiding gaps in prescription drug coverage, preserving beneficiary choice and market stability, and preventing substantial increases in costs to beneficiaries resulting from crosswalks,"⁵⁴ we emphasize the high importance of insuring that enrollees get advance notice of any crosswalk, and **recommend that plans be required in those notices to provide the contact information for the local State Health Insurance Assistance Program (SHIP) so that enrollees can reach out to their SHIP for independent advice on their options.**

We object, however, to CMS's proposed rule, at § 423.530(c)(1)(v), regarding consolidated renewal crosswalks and enrollee costs. CMS has proposed to change its current policy so that "when a PDP sponsor chooses to crosswalk in a consolidated renewal scenario," CMS will "require enrollees from non-renewing PBPs offering enhanced alternative coverage to be crosswalked into the PBP that will result in the *lowest premium increase*."⁵⁵ The plan with the lowest premium, however, is not necessarily the plan with the lowest overall out of pocket costs for the enrollee. A very low monthly premium is in fact often offset by a high deductible and/or pharmacy co-insurance payments. Enrollees should instead be crosswalked, if at all, to an equivalent plan that has the lowest estimated out of pocket costs.

CMS should—as it has suggested—instead use "differences in estimated out of pocket costs (OOPC) between the non-renewing and surviving PBPs, rather than simply the difference in plan premiums, to

⁵³ NPRM, 87 Fed. Reg. at 79,601 *et seq.*

⁵⁴ NPRM, 87 Fed. Reg. at 79,601.

⁵⁵ NPRM, 87 Fed. Reg. at 79,603 (*emphasis added*).

determine whether approving a plan crosswalk exception is the best option for enrollees in a non-renewing PBP.”⁵⁶

Other Proposed Rules that We Support as Written

Given our focus on equity and access to care for low income older adults, we note the following other rules that we particularly appreciate and strongly support as drafted:

- II.B. Part D SEP for Individuals Who Enroll in Part B During the Part B General Enrollment Period (§ 423.38(c)(16))⁵⁷
- II.C. Alignment of Part C and Part D Special Enrollment Periods with Medicare Exceptional Condition Enrollment (§§ 422.62 and 423.38)⁵⁸
- II.E. Expanding Eligibility for Low-Income Subsidies Under Part D of the Medicare Program (§§ 423.773 and 423.780)⁵⁹
- Required Notices for Involuntary Disenrollment for Loss of Special Needs Status (§ 422.74)⁶⁰ (comports with other proposed rules designed to reduce unnecessary disenrollment)
- Updating MA and Part D SEPs for Changes in Residence and Codifying Procedures for Developing Addresses for Members Whose Mail Is Returned as Undeliverable (§§ 422.62, 422.74, 423.38 and 423.44)⁶¹ (important for enrollees who live in rural areas)
- Part D Sponsor Website Requirements (§§ 423.2265(b)(12) and 423.2265(c)(1)(vi))⁶² (requiring “that a Part D sponsor's utilization management criteria, as approved by CMS, must be posted on the plan's website by October 15 prior to the plan year”)

Thank you again for the opportunity to comment in support of these important changes to Medicare Advantage and Part D regulations. If any questions arise concerning this submission, please contact Murray Scheel, Senior Staff Attorney, at mscheel@justiceinaging.org and [Georgia Burke, Director of Medicare Advocacy at gburke@justiceinaging.org](mailto:gburke@justiceinaging.org).

Sincerely,



Georgia Burke
Director, Medicare Advocacy

⁵⁶ NPRM, 87 Fed. Reg. at 79,604.

⁵⁷ NPRM, 87 Fed. Reg. at 79,466-67.

⁵⁸ NPRM, 87 Fed. Reg. at 79,467.

⁵⁹ NPRM, 87 Fed. Reg. at 79,478.

⁶⁰ NPRM, 87 Fed. Reg. at 79,570.

⁶¹ NPRM, 87 Fed. Reg. at 79,583, *et seq.*

⁶² NPRM, 87 Fed. Reg. at 79,606.