JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

January 5, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4205-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program (CMS 4205-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 NPRM and are presented in the order discussed there.

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Program

A. Expanding Network Adequacy Requirements for Behavioral Health (§§ 422.116(b) and 422.116(d)(2))

Justice in Aging supports the establishment of network adequacy standards for Outpatient Behavioral Health, including time and distance standards. The Centers for Medicare and Medicaid Services (CMS) has taken commendable steps in recent years to expand the availability of mental health and substance use disorder (SUD) treatment including the coverage of mental health counselors (MHCs), marriage and family therapists (MFTs), and opioid treatment programs (OTPs). Network adequacy standards are essential in ensuring access to these newly covered providers and are particularly important in access to

treatment for individuals dually eligible who are more likely to have mental health and substance use disorder diagnoses than individuals with Medicare only.[1]

However, while Justice in Aging greatly appreciates the movement toward network adequacy standards for behavioral health, we are concerned that the proposed standards do not adequately reflect how these services are delivered or used by those seeking treatment. Specifically, the proposal combines mental health and SUD providers into one category. Doing so would not ensure access specifically to SUD treatment, including treatment for alcohol use disorder and opioid use disorder and the full scope of medications for addiction treatment. Further, the proposed time and distance standards depart significantly from more appropriate standards recently established for Qualified Health Plans (QHPs), many of which also operate Medicare Advantage plans. We endorse the comments submitted by the Legal Action Center and **recommend that CMS require separate network adequacy standards for Outpatient Mental Health and for Outpatient Substance Use Disorder**. **We also recommend that CMS shorten the maximum time and distance standards to align with the standards for QHPs**.

H. Update to the Multi-Language Insert Regulation (§§ 422.2267 and 423.226)

Justice in Aging strongly supports the proposal to amend §§ 422.2267(e)(31) and 423.2267(e)(33) to require Medicare Advantage (MA) and Part D plans to provide a Notice of Availability (notice) in English and at least the 15 languages most commonly spoken by individuals with Limited English Proficiency (LEP) of the relevant state. As CMS explains, this change from the top 15 languages nationally to the top 15 languages in each state will better align with Medicaid requirements and the proposed Affordable Care Act Section 1557 requirements. Most importantly, it will improve the ability of more of the 4.1 million Medicare enrollees with LEP to understand their coverage and advance health equity among populations for whom language access has been a barrier to high-quality care.

We also strongly support requiring plans to provide the Notice of Availability in alternate formats and notify individuals (in each required language) of the availability of auxiliary aids and services to ensure effective communication for individuals with disabilities. In addition to bringing the Medicare requirements into alignment with other similar notice requirements, this change is particularly important given the prevalence of visual and other disabilities among the Medicare population.

CMS is also proposing to no longer specify the exact text that plans must use in the required notice, but will require plans to include the specific elements listed in the proposed regulatory text. We agree with this approach and urge CMS to routinely review plans' notices for compliance and provide model text.

We appreciate that CMS will also continue to require plans to include the Notice in additional languages that meet the 5% threshold in the plan service area. However, we urge CMS to expand the reach of this trigger by amending the threshold. We continue to hear from advocates that many older adults who are LEP do not know they have a right to an interpreter and translations when receiving healthcare or interacting with their health plan. Even those who are aware of their rights can be pressured by providers to do without. Having this Notice in language for as many enrollees as possible is critical—it is

[1] CMS. "Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (MMLEADS PUF V2.0)" (2006-2012) (09/15/2020) (XLSX).

a prompt to start language access services and protections for the most significant healthcare interactions.

As CMS acknowledges, there may be populations in a plan service area that use a language that does not fall within the top 15 languages for the state or meet the 5% threshold. In fact, the 5% trigger neglects many substantial non-English speaking communities throughout the country, leaving those older adults and people with disabilities without the appropriate language access to readily understand their coverage. Under the 5% threshold, a community of 10,000 people who are LEP in a metropolitan area of one million people would not necessarily be notified of their right to an interpreter. Our review of American Community Survey (ACS) data on the most common languages in each state reveals that the 5% threshold leaves out many large LEP communities[2]:

- In Florida, there are nearly **14,000 Bengali speakers, 5,500 of whom (40%) are LEP**. Bengali is not in the top 15 languages for the state (either by total speakers or people with LEP) and is unlikely to meet the 5% threshold in any plan service area.
- In California, **Indonesian is the primary language for over 13,000 people who are LEP**. It is well outside the top 15 languages and unlikely to meet the 5% threshold in any service area in such a populous state.
- In New York, languages like **Japanese, Hindi, Portuguese, Vietnamese, Ukrainian, and Hebrew, each with more than 10,000 speakers who are LEP,** might not meet any of these thresholds.
- In Georgia, **57% (3,100 people) of the 5,400 people who speak Nepali are LEP**. Nepali would not meet the 5% threshold nor the top 15 languages.
- In Ohio, the 5% threshold would not capture the **2,670 Swahili speakers who are LEP**.
- In Maryland, **over half of the Burmese speaking population (2,500 people) is LEP**. Burmese is not in the top 15 languages and unlikely to meet the 5% threshold. **Japanese, with 2,800 LEP individuals**, is also outside the top 15.

While we appreciate the reminder to plans that they have the option to include the Notice of Availability in additional languages, we strongly urge CMS to create a numerical threshold that would capture more languages. Specifically, **we recommend setting a threshold of either 5% or 1,000 people, whichever is lower, in a service area who speak a language other than English as triggering both the Notice of Availability and the translation requirement for vital documents**. Adding additional languages to the Notice of Availability is a small lift, as it does not require plans to create a new insert. We recognize the translation of vital documents into additional languages is a bigger lift. However, we believe such a requirement is equally warranted when it will ensure meaningful access for thousands of people. We hear from community-based organizations serving older adults and people with Medicare who are LEP that such translated notices and documents are hugely beneficial to their work. The translated Notice empowers older adults to reach out to their plan on their own. Translated plan documents, which are often technical, not only empower the enrollee to advocate for themselves, they also save the people at CBOs assisting LEP individuals time and effort of having to understand and translate this information.

[2] Author analysis of 5-year American Community Survey PUMS data (2017-2021).

Finally, we recommend CMS publicly publish its methodology for determining both the top 15 languages statewide and additional languages meeting a threshold in a plan service area. In addition, CMS should post and update annually the lists of the top 20 languages most commonly spoken by individuals with LEP in each state. Including 20 languages on this list will help advocates identify languages that might meet the plan coverage area threshold even if they are not on the list of top 15 for the state. As CMS already calculates and provides plans with a list of all languages meeting the 5% threshold in every county, making that more detailed information available and easily accessible to Medicare advocates would be welcome. For example, we recommend requiring MA and Part D plans to publicly post on their websites the required languages, including the top 15 in the relevant state and any additional languages meeting the threshold in each of their service areas. Without this information, it is unlikely an individual or advocate would know whether they should be receiving the Notice and translated documents in their language.

I. Expanding Permissible Data Use and Data Disclosure for MA Encounter Data (§ 422.310)

Justice in Aging supports the proposal to expand MA encounter data to support the Medicaid program by adding "and Medicaid program" to § 422.310(f)(1)(vi) and (vii). We agree with CMS that this expansion will help states improve their Medicare and Medicaid integrated products. Because this expansion would also include non-integrated products, states can use the data to obtain a clearer picture of how individuals dually eligible are being served across health plan types. States could also use this data to better identify and address disparities. We encourage CMS to provide guidance and best practices to states on how to utilize this data to its full potential.

IV. Benefits for Medicare Advantage and Medicare Prescription Drug Benefit Programs

B. Evidence as to Whether a Special Supplemental Benefit for the Chronically Ill Has a Reasonable Expectation of Improving the Health or Overall Function of an Enrollee (§§ 422.102(f)(3)(iii) and (iv) and (f)(4))

Justice in Aging supports CMS's proposal to shift the burden from CMS to MA plans for establishing whether a Special Supplemental Benefit for the Chronically Ill (SSBCI) has the reasonable expectation of improving the health or overall function of an enrollee. We are deeply concerned MA plans are primarily utilizing SSBCI offerings as a means of growing health plan enrollment with little evidence that these benefits are improving health outcomes. We are particularly concerned regarding the growing trend of MA plans offering cash benefits to drive enrollment. Between plan year 2022 and plan year 2023, for example, the number of plans offering food and produce grew by 22% while the number of plans offering "general supports for living" grew by 61%.[3] At the same time, enrollment in MA plans grew by 11% percent. Enrollment in Dual Eligible Special Needs Plans (D-SNPs) was even higher with growth of 25% from 2022 to 2023.[4]

Shifting the burden to MA plans to provide a bibliography of available evidence supporting their bid to offer these SSBCI is minimal in light of the substantial amount of federal funding plans received through

[3] ATI Advisory, "New, Non-Medical Supplemental Benefits in Medicare Advantage in 2023," (Feb. 21, 2023).
[4] Nancy Ochieng et. al., KFF, "Medicare Advantage in 2023: Enrollment Update and Key Trends," (Aug. 9, 2023).

rebates and the growth in enrollment these plans are reaping from these offerings. We do not believe that this requirement will overly burden plans or hinder innovation. CMS should publicly publish the bibliographies for SSBCI in a compendium or other format.

We also urge CMS to undertake a more thorough examination of cash card benefits specifically. Advocates on the ground report that many of their clients are joining MA plans because they are being offered SSBCI as cash cards in amounts as high as $300 a month, which for nearly 1 in 5 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%.[5]

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 MA Plan. The reward is advertised without an explanation of the potential risks as we describe in more detail below. We also have heard from community-based organizations that steer people towards MA plans that offer cash card benefits, without fully understanding the trade off in terms of limited networks and prior authorization. Consequently, cash benefits could have an adverse impact on access to health care and health outcomes and warrants close examination and oversight from CMS.

Additionally, we renew our request that **CMS provide clarity on how these cash benefits would or would not affect eligibility for low-income programs such as Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Supplemental Security Income (SSI).** Although we believe that in almost all cases, these benefits would be exempt from program counting because they are health related, guidance is needed to ensure that this is the outcome for Medicare enrollees receiving these cash benefits.

We frequently hear from advocates that Medicare enrollees are concerned about how these benefits will affect eligibility for other programs and some are hesitant to use these cards because of the potential risk they pose for other program eligibility. For example, advocates have indicated their concern regarding these benefits being counted against subsidized housing eligibility, where housing providers already have a history of incorrectly attempting to count other types of assistance like utility assistance as income when determining rent. Other advocates are concerned that the Social Security Administration (SSA) – or individual case workers—may consider these cash benefits as unearned income when determining SSI eligibility.

We ask that CMS, in consultation with SSA, HUD, and the Department of Agriculture, provide guidance so that agencies, states, enrollees, and plans have clear direction and so that program offerings and benefit rules align. We recommend that CMS not allow MA plans to offer these benefits if they are determined to affect eligibility for other programs. Regardless of CMS determination, MA plans should be required to inform enrollees and potential enrollees of the impact cash benefits either do or do not have on other benefits.

[5] Maria Pena, et. al., KFF, "A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)," (Jan. 31, 2023).

We also strongly urge CMS to require D-SNPs to provide additional evidence of whether a supplemental benefit has a reasonable expectation of improving the health outcomes of enrollees when the benefit overlaps with a Medicaid covered benefit for individuals who are dually eligible. Many D-SNPs offer supplemental benefits (whether mandatory, optional, SSBCI, or through uniformity flexibility) that are already covered by Medicaid. To ensure that these supplemental benefits have an expectation of improving the health of enrollees, D-SNPs should be required to offer evidence of their added value and that the benefit does not just duplicate already available benefits. For example, D-SNPs that offer transportation for a limited number of trips to medical appointments are both duplicative and less comprehensive than the Medicaid transportation benefit federally required to cover *all* trips to medical appointments. When a D-SNP offers this type of supplemental benefit, the benefit is illusory with no impact on health. In other instances, these offerings can act to hinder access to Medicaid covered benefits and result in adverse health outcomes because the D-SNP and Medicaid benefits are not coordinated.

We support CMS's proposal clarifying that MA plans must both maintain *and* apply their written policies for determining a chronically ill enrollee's eligibility to receive a particular SSBCI. **We strongly encourage CMS to require that MA plans make these written policies both available to CMS and to the public on their website**. Doing so will help both providers and enrollees know in advance the applicable criteria and whether the benefit would be available to them if they enroll, and in the event of a denial, facilitate resolving an appeal at the lowest possible level. This information would also help individuals make informed plan choices as they could assess whether they would be eligible for a particular SSBCI before enrolling.

We oppose allowing MA plans to change plan rules regarding SSBCI during the year. MA plans heavily market the availability of SSBCI and those who enroll in the plan rely on the continued availability of these benefits throughout the year. Absent an exceptional circumstance as approved by CMS, MA plans should make these benefits available using the same utilization management requirements, evidentiary standards, and objective criteria for the entirety of the plan year. If CMS permits this change, CMS should create a Special Enrollment Period (SEP) that allows enrollees to disenroll from the MA plan based on changes to plan rules.

We support CMS's proposal to require MA plans to document each instance they determine an enrollee ineligible for SSBCI and agree that such a requirement will allow CMS to better monitor inequities in access to SSBCI based on race or other factors. As we describe in more detail below, MA plans should also be required to report utilization of all supplemental benefits including SSBCI with accompanying demographic data.

We also reiterate our concerns that SSBCI have not been extended to the majority of individuals who choose to remain in original Medicare and that their availability and accessibility even within Medicare Advantage is limited. We urge CMS to support expanding availability of these benefits to all Medicare enrollees who could benefit through both legislation and administrative means such as through Center for Medicare and Medicaid Innovation (CMMI) demonstrations.

C. Mid-year Enrollee Notification of Available Unused Supplemental Benefits (§§ 422.111(l) and 422.2267(e)(42))

We support CMS's proposal to notify Medicare enrollees of unused supplemental benefits at the mid-year point through a standardized notice. Like CMS, we are concerned that many of the supplemental benefits that are marketed to enrollees go unused. We are particularly concerned benefits go unused in instances where MA plans offer a "menu" of supplemental benefits an individual can choose from to use throughout the year. Requiring health plans to send a notice of unused benefits is a low-burden method of increasing enrollees' knowledge of the availability of the benefit(s) and how to access them. The notice should be written in plain language and accompanied by the multi-language Notice of Availability. CMS should consider additional means in which health plans can communicate the availability of supplemental benefits throughout the year to members. For example, CMS could mandate more prescriptive requirements in D-SNP models of care.

We are pleased to see that CMS has finalized its rule to require MA plans to report utilization and cost data for all supplemental benefit offerings (88 FR 15726).[6] This data is necessary to effectively monitor the extent in which MA plans are providing supplemental benefits and identify disparities in the provision of benefits. As we wrote in our comments on that rule, **CMS should require plans to report demographic data with the proposed utilization and cost measures.**[7] Utilization and cost data paired with demographic data is necessary to determine whether MA plans are providing equitable access to supplemental benefits. Specifically, CMS should add disaggregated reporting fields for race/ethnicity; age; rural/urban status; disability, language, sex, sexual orientation, and gender identity. This demographic data collection promotes Executive Order 13985, which calls for advancing equity for underserved populations, and advances the goals and objectives outlined in the CMS Framework for Health Equity 2022-2032 and the HHS Equity Action Plan.[8] We also ask that **CMS make the data it collects from Medicare Advantage plans publicly available and request CMS to review and analyze the data in its oversight capacity and the data be collected and maintained in formats that facilitate analysis by researchers and other analysts**.

D. Annual Health Equity Analysis of Utilization Management Policies and Procedures (§§ 422.137(c)(5) and 422.137(d)(6))

We support CMS's proposal requiring MA plans to: (1) Include an expert in health equity on the utilization management committee; and (2) Conduct and make publicly available an annual health equity analysis of prior authorizations, which includes analysis for prior authorization approval rates. We appreciate that this proposal builds on last year's final rule that requires MA plans to establish a utilization management committee by ensuring the committee is equipped to identify and address disparities in how prior authorizations are employed and inhibit access to care for marginalized populations. To make sure this proposal accomplishes this goal, we recommend the following:

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[6] CMS, "Medicare Part C Technical Specifications Document Contract Year 2024," p. 43 (Dec. 27, 2023).
[7] Justice in Aging, "Comments on Agency Information Collection Activities: Proposed Collection; Comment Request, CMS-2023-0041," (May 4, 2023).
[8] Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," 86 FR 7009 (2021); CMS, "Framework for Health Equity 2022 – 2032"; HHS, "Health Equity Action Plan."

- **Establishing uniform definitions.** Categories should be precisely defined by CMS in order to maximize the usefulness of the data in understanding and comparing across plans. For example, the definition of "dually enrolled" individuals should specify whether data for individuals who are not in full Medicaid are included. Of particular note, the social risk factor analysis could be especially prone to variability in methodology across plans. The proposed rule could be interpreted by one plan to look at the three categories (dually enrolled individuals; individuals on LIS; individuals with a disability) as one category, two categories, or three. Justice in Aging urges precise, uniform instructions to allow for plan data to be comparable.

- **Establishing uniform format.** The data should be collected in a uniform format to reduce the administrative burden of comparing plans. For example, reports should be submitted in spreadsheet form, ideally on a template provided by CMS with clear definitions and instructions.

- **Require numbers underlying percentages.** In the proposed rule, CMS requires plans to submit seven data elements as percentages (e.g., percentage of prior authorization denials that were approved upon appeal). CMS should also require data underlying the percentages (e.g., number of prior authorization denials that were appealed and number of appeals that were denied). Providing the total numbers (not just the percentages) allows for more meaningful understanding of the scope of prior authorization issues.

We also recommend that additional data be gathered to offer a more complete picture of prior authorization issues and MA policies, including:

- **Disenrollment data.** Prior authorization can lead individuals with complex health conditions and disabilities to disenroll. There is evidence, for example, that the population that switches form MA plans to traditional Medicare is more likely to be dually enrolled in Medicare and Medicaid, and more likely to be in poor health.[9] Justice in Aging suggests that plans be required to include data about how many individuals disenroll from their plan following a prior authorization decision.

- **Disaggregated data by type of item and service.** Prior authorization data should be broken out by categories of items and services. We have heard reports that plans are routinely denying certain types of services, including for example nursing facility stays. 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.

- **Demographic data.** The Social Risk Factor populations in the proposed rule (dually enrolled individuals; individuals on LIS; individuals with a disability) should be separated into full duals and partial duals. Additional demographics, including race, ethnicity, LGBTQ+, and LEP status, should be included as discussed in more detail below.

[9] Commonwealth Fund, "Medicare: A Policy Primer," (May 3, 2022) ("Notably, the people who switched to traditional Medicare have been shown in multiple studies to be disproportionately dually eligible for Medicare and Medicaid, living in rural areas, in poorer health, needing more help with activities of daily living, and to use more health care services than people who do not switch, raising questions about plans' provider networks and quality of care for sicker populations. There is speculation that the ability of Medigap insurers to deny or set premiums based on health status in most states hinders more people from switching to traditional Medicare.").

- **Require timely reports.** There should be a deadline for the annual report submission, and consequences if the report is not submitted on time. In order for the data to be useful in helping to compare plans and address access issues in a timely manner, the data must be recent.

We strongly recommend that CMS require MA plans to include additional populations in the health equity analysis in addition to dual eligibility, Low-Income Subsidy (LIS) status, and disability. Discrimination based on age, race, ethnicity, LGBTQ+, and LEP status adversely impact access to health care that is distinct and compounded by income and disability. For example, Black people are four times as likely to develop kidney failure as white people, but they are significantly less likely to receive a kidney transplant.[10] Similarly, Black people also experience the highest rates of heart failure, but receive heart transplants at lower rates than their white counterparts.[11] The COVID-19 pandemic illuminated the extent of discrimination people face based on age and disability in accessing health care.[12]

MA plans should be required to include age, race, ethnicity, LGBTQ+, and LEP status in their equity analyses and CMS should provide uniform instructions on how to collect and report this data to ensure consistency and comparability across plans. We also support CMS's proposal to require plans to include the equity analysis publicly on their website in an accessible format and that CMS also require plans to provide such website links to CMS to post in a centralized location. In addition to the report being made available, the uniform, plan-specific data should be made publicly available in an accessible format for researchers and advocates to review and analyze.

Lastly, given the extent and severity of the use of prior authorizations impeding access to medically necessary care for MA plan enrollees, we urge CMS to undertake more oversight to curtail inappropriate prior authorization actions by MA plans.

V. Enrollment and Appeals

Justice in Aging broadly supports the changes in Section V of the proposed rule, addressing enrollment, appeals, and reporting. We appreciate the attention to detail around areas where enrollees may run into barriers accessing their Medicare benefits, and amending the rule to make the process smoother.

D. Amendments to Establish Consistency in Part C and Part D Timeframes for Filing an Appeal Based on Receipt of the Written Decision (§§ 422.582, 422.584, 422.633, 423.582, 423.584, and 423.600)

Justice in Aging supports the proposal to add five days to the 60-day appeal timeframe in response to a written decision by an MA or Part D plan, and to add more days to the appeal timeframe if there is evidence that the written determination was received later than five days after mailing. This proposal is

[10] Boulware, L.E. et al., "Systemic Kidney Transplant Inequities for Black Individuals: Examining the Contribution of Racialized Kidney Function Estimating Equations," JAMA Netw Open 4(1)(Jan. 2021);
[11] Chouairi, F. et al., "Evaluation of Racial and Ethnic Disparities in Cardiac Transplantation," JAHA 10(17) (Aug. 2021).
[12] Justice in Aging et al., "Examining How Crisis Standards of Care May Lead to Intersectional Medical Discrimination Against COVID-19 Patients," (Feb. 10, 2021).

consistent with appeals timeframes in Medicare more generally and provides needed clarity for enrollees and their representatives.

The proposal also reflects the lived experience of enrollees. Post office delivery times have slowed in recent years, with the post office making a permanent change slowing first class delivery in 2022.[13] Some states, including Florida, Colorado, and Georgia, experience slower service than the rest of the country.[14] Furthermore, frequent address changes requiring forwarding of mail are common for low-income populations, due in large part to the difficulty accessing affordable housing. In one study of a state's Medicaid population, more than one in ten members had more than three addresses in the past year or were unhoused.[15] The proposed rule allows for time to appeal decisions, particularly for lower income individuals affected by delayed mail receipt.

VI. Medicare Advantage/Part C and Part D Prescription Drug Plan Marketing and Communications

A. Marketing and Communications Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.2267)

Justice in Aging supports CMS's proposal to make SSBCI marketing more transparent and clearer for Medicare enrollees. The fact that SSBCI are only available under limited circumstances is often not clear to Medicare enrollees. This is particularly an issue in TV and radio advertisements where disclaimers, if present, are read quickly and within the advertisement's promises of saving money and additional benefits. Requiring MA plans to list the chronic conditions that are required for eligibility; to clearly state that additional requirements apply for eligibility; and to include disclaimers on all advertisements in a certain format with specific font size and voice speed will help to make SSBCI marketing clearer and less misleading for enrollees. The vast majority of Medicare enrollees rely on advertisements for information about choosing a MA plan[16], highlighting the importance of monitoring TV and radio advertisements for misleading marketing.

We recommend that CMS make the model disclaimer language even clearer by explicitly stating that not everyone who has Medicare is eligible for the benefit. This disclaimer should also explicitly say how enrollment in an MA plan differs from traditional Medicare. We suggest the following additions [italicized]:

"Not all people with Medicare are eligible for this benefit. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. *Individuals who enroll in an MA plan are required to see providers contracted*

[13] United States Postal Service, "Revised Service Standards for Market-Dominant Mail Products," 86 Fed. Reg. 43,941 (Aug. 11, 2021) (final rule) (changing first class standards from 1-3 days to 1-5 days).
[14] United States Postal Service Office of the Inspector General, USPS Service Performance.
[15] Arlene Ash et. al., "Social Determinants of Health in Managed Care Payment Formulas," JAMA Intern Med. 177(10) (October 2017).
[16] Leonard, Faith et. al., Commonwealth Fund, "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why," (October 17, 2022).

with the health plan and prior authorization may be required. For details, please contact us *or visit our website*."

As noted in our comments above, **CMS must also require MA plans to make available their written SSBCI eligibility criteria publicly and easily accessible**. To make informed choices, Medicare enrollees, their representatives, and State Health Insurance Assistance Program (SHIP) counselors should be able to easily review an MA plan's SSBCI offerings and the SSBCI eligibility criteria.

We also urge CMS to prohibit misleading marketing of SSBCI that duplicate Medicaid benefits. MA plans frequently advertise the availability of benefits to which individuals dually eligible are already entitled to receive more comprehensively in both duration and scope under Medicaid. A recent illustration of this misleading marketing occurred in Connecticut where an MA plan heavily marketed to individuals dually eligible promising no cost-sharing, dental, vision, and transportation – all of which are benefits already covered comprehensively by Medicaid.[17] Yet, the MA plan's marketing materials suggested that individuals who enroll would receive more than what they would receive in Original Medicare. In reality, there was only one benefit that was potentially "extra" – the $130 credit for healthy food, OTC products, and utility bills. Meanwhile, the disclaimer noted only that "limitations, exclusions, and/or network restrictions may apply." Advocates report that many dually eligible individuals are lured by these ads and report not understanding the limits of the "extra" benefits or restrictions, highlighting the need for clearer and more robust disclaimer language than contemplated by this rule.

B. Agent Broker Compensation

We remain concerned that MA broker and agent compensation does more harm than good for Medicare enrollees. Investments in SHIPs to provide unbiased and comprehensive education regarding enrollment options, including original Medicare, PACE, Accountable Care Organizations (ACOs), and MA plans would better serve the health care needs of enrollees. Today, SHIPs receive a total of $70 million in federal funding to counsel 65 million older adults and people with disabilities.[18] Meanwhile, Marketplace enrollment counselors receive $90 million in federal funding to counsel 19 million individuals.[19] We believe investments in SHIPs and limitations in broker and agent activity is particularly necessary for dually eligible individuals who face more complex enrollment choices and have higher rates of complex care needs. Accordingly, we urge CMS to consider additional restrictions on agent and broker activity beyond the proposals in the NPRM while simultaneously making more investments in SHIPs and enrollment counseling.

We support CMS's efforts to address broker compensation in order to limit the improper steering of Medicare enrollees into plans that do not meet their needs. Focus groups with agents and brokers demonstrate that compensation can create financial incentives that are not aligned with the interests of

[17] Disability Rights Connecticut, the National Health Law Program, the National Disability Rights Network, and the Center for Medicare Advocacy, "Letter to CMS and FTC: Misleading Advertising by Medicare Advantage Plans to Medicaid/Medicare Enrollees; Request for Immediate Relief Against UnitedHealthcare; Broader Nationwide Investigation and Relief Needed," (Dec. 7, 2023).
[18] Congressional Research Service, "State Health Insurance Assistance Program (SHIP)," (Oct. 23, 2023).
[19] Karen Pollitz, et. al., KFF, "2022 Survey of ACA Marketplace Assister Programs & Brokers," (Oct. 17, 2022).

Medicare enrollees.[20] We urge CMS to create parity in compensation among MA, Prescription Drug Plans (PDPs), and Medigap so that brokers and agents are not unduly incentivized to steer individuals into MA plans when remaining original Medicare with a standalone PDP and/or a Medigap plan would better serve the enrollee. Even if it is not CMS's intent, brokers and agents believe that, based on the compensation rates authorized by CMS, "[it seems] as if the federal government wants more people to be in Medicare Advantage."[21]

We also urge CMS to take additional measures to ensure broker activity is not leading to enrollment in MA plans that do not meet Medicare enrollee's needs. While compensation is a significant factor in influencing broker activity, it is not the only factor. It is not surprising that complaints to CMS regarding broker activity have increased significantly as MA plans have increased their offerings of SSBCI. The complexity of these offerings and lack of transparency regarding who can receive benefits creates an environment ripe for overselling and confusion – even if not intentional. **Again, we strongly urge CMS to require health plans to publicly make available the eligibility criteria for SSBCI offerings**. Requiring that the eligibility criteria is public would also ensure brokers and agents have access to this information to better inform enrollees of their options as well as empower Medicare enrollees, their representatives, and SHIP counselors and place an important check on broker and agent activity.

Brokers and agents should also be required to clearly explain how enrollment in an MA plan will require members to see providers only contracted with that plan, that prior authorizations might be required to access care and treatment, and that they might need to switch the drugs they are taking. It is also very problematic that brokers and agents do not have to present all plan options available in a service area. CMS should require brokers and agents to inform enrollees that the options they are presenting may not include all the options available to enrollees in their area and to review Medicare Plan Finder and consult with a SHIP counselor for the full array of offered plans. As noted above, while outside the scope of this rulemaking, we strongly encourage CMS to secure additional funding to expand and better support SHIPs as they play an invaluable role as the free, unbiased resource for the more than 65 million Medicare enrollees.

We also believe CMS can do more to shield individuals dually eligible from misleading broker and agent activity. As we commented above regarding SSBCI marketing, **agents and brokers should also be required to explain what benefits are already covered by Medicaid and what the MA plan is offering as "extra."** Again, we are particularly concerned about agent and broker marketing of cash benefits to dually eligible enrollees. Even when enrollees indicate that they do not want to switch plans, brokers and agents are pressuring them to make a change to access cash benefits when the change would result in disruptions in care.[22] As we commented above, CMS should closely evaluate cash benefit offerings and their impact.

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[20] Faith Leonard et. al., Commonwealth Fund, "The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents," (Feb. 28, 2023).
[21] *Id*.
[22] See, for example, Leslie Walker and Dan Gorenstein, "Medicare Shoppers Often Face a Barrage of Unsolicited Calls and Aggressive Ads," NPR (Oct. 16, 2023).

Lastly, we ask that CMS more timely update its marketing and other subregulatory guidance. Frontline advocates and SHIP counselors assisting Medicare enrollees rely on the Medicare marketing guidelines to assist their clients and enforce their rights, and yet, the Medicare Communications and Marketing Guidance posted online was last updated in February 2022 despite significant changes being finalized in April 2023 for plan year 2023.[23] We also urge CMS to post Health Plan Management System (HPMS) memos with active links. Today, HPMS memos are not searchable and only available in weekly zip files to download as PDFs.

VIII. Improvements for Special Needs Plans

General Comment

We are very supportive of CMS's efforts to improve special needs plans and increase integration for individuals dually eligible for Medicare and Medicaid. However, as CMS moves to reduce the overwhelming number of health plan choices available to dually eligible individuals and increase enrollment in integrated plans, CMS must adopt stronger requirements and exercise its enforcement powers to improve the integration and quality of care these plans are responsible for delivering. Limiting choice is broadly perceived as a negative outcome. For low-income individuals and marginalized populations there is even more skepticism when their health care choices are limited in light of their lived experience with receiving less access and lower quality of care. **If Medicare enrollees are to embrace less or different choices for better integrated and improved access to care, then the integrated MA plans actually have to deliver**.

CMS also must invest in better educating Medicare enrollees, their representatives, and the public regarding the benefits of integrated coverage options. It is counter-intuitive that MA plans available to higher-income individuals are less beneficial for lower-income dually eligible individuals. Changes to Medicare Plan Finder, as suggested below, will help to advance this goal, but CMS should be taking additional measures to standardize and promote educational materials regarding integrated options for dually eligible enrollees.

One key step CMS could take to improve integrated care is to **require all D-SNP providers to accept Medicaid** – particularly providers responsible for delivering supplemental benefits that overlap with Medicaid benefits. New York Legal Assistance Group's comments on this proposed rule include a client example we hear frequently: the dually eligible individual was enrolled in a D-SNP that offers a limited supplemental dental benefit up to $1,000. Meanwhile, New York's Medicaid program offers extensive dental coverage. The enrollee received approximately $10,000 in dental services – all of which would have been free had he not been enrolled in the D-SNP. Instead, the plan only paid $1,000 leaving the enrollee with a $9,000 bill because the D-SNP dental provider did not accept Medicaid. Since the service is supplemental and not a Medicare-covered service, Qualified Medicare Beneficiary (QMB) protections and 42 CFR 422.504 (g)(1)(iii) do not prohibit balance billing by the provider. It is hard to argue in these cases that the D-SNP's network meets the needs of the dually eligible population served as CMS requires.[24]

[23] CMS, "Medicare Marketing Guidelines," last accessed Jan. 3, 2024.
[24] CMS, "Medicare Managed Care Manual Chapter 16-B: Special Needs Plans," Section 20.2.2, #5.

Ombuds Program

We note that one of the provisions not included in this proposal is an ombuds program. The proposals outlined below are incredibly complex and build on an already complex policy and health plan landscape for dually eligible individuals. One of the major successes of the Financial Alignment Initiative (FAI) was the use of an ombuds program to assist individuals in navigating Medicare-Medicaid Plans (MMPs). In our experience, we saw that they were able to explain program rules, assist in enrollment and disenrollment, and resolve issues that otherwise might have required lengthy appeals. Ombuds programs also had multiple successes in identifying systemic issues. The relationships that ombuds built with state agencies, CMS, and health plans brought value to all parties and significantly helped to improve program operation. The value of an ombuds program for enrollees in D-SNPs would be the same or greater.

We recognize that many state Medicaid programs have ombuds, but it is important that there be ombuds staff who are specifically dedicated to the complex issues that people dually eligible for Medicare and Medicaid face and are well-versed in benefits and individual rights in both programs. The FAI provided dedicated funding for ombuds and we believe it was money well spent. We urge CMS to require and fund ombuds programs to serve individuals enrolled in D-SNPs.

C. Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization (§§ 422.503, 422.504, 422.514, 422.530, and 423.38)

1. Changes to the Special Enrollment Periods for Dually Eligible Individuals and Other LIS Eligible Individuals

We strongly support CMS's proposal to create a new continuous dual Special Enrollment Period (SEP) for individuals who are dually eligible or LIS eligible that would permit them to disenroll from an MA plan or PDP plan on a monthly basis. In 2019, we strongly opposed the elimination of the LIS SEP and creation of the quarterly SEP finalized and currently in place. As we noted then, older adults and people with disabilities who qualify for Medicaid or LIS are more likely to have multiple chronic conditions and complex medical and prescription drug needs, but are less likely to have the financial resources to weather any disruption or denial of care.

Since 2019, the number of plans operating, as well as plan design and benefit offerings, have only become more complex for low-income Medicare enrollees. At the same time, low-income enrollees are increasingly subject to passive and default enrollment.[25] These individuals may need to switch plans because of changes to their own medical needs, including new medications unrelated to the quarterly lock-in, or because of other changed circumstances or preferences. A continuous SEP importantly allows them to maintain access to care and prescription drugs and aligns with the SEP statutory protections for people eligible for both Medicare and Medicaid.[26]

We also support CMS's proposal to create a new integrated care SEP for dually eligible individuals that would allow enrollment in any month into a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP), or Applicable Integrated Plan

[25] Sixty-two separate plans in 12 states and Puerto Rico have approval to use default enrollment as of June 30, 2023. CMS, "Default Enrollment Policy and Data on Approved Medicare Advantage Plans," July 7, 2023.
[26] 42 U.S.C. § 1395w-101(b)(3)(D).

(AIP). We have heard from advocates that individuals wish to enroll in an integrated plan, but must wait until the next quarter or the annual election period. For example, a dually eligible individual in rural California wanted to enroll into the county's Medicare and Medicaid plan in order to access a specific behavioral health provider. However, she had to wait until January 1 for her enrollment to be effective because she enrolled in the beginning of the annual election period. Importantly, this proposal advances integrated care options for dually eligible individuals – a policy goal Justice in Aging strongly supports – while also ensuring that dually eligible individuals or LIS recipients do not have fewer enrollment options than those who are not LIS or dually eligible.

We believe this proposal could also encourage MA organizations to operate and invest in more integrated D-SNP plans since Medicare enrollees would only be able to enroll in the more integrated D-SNPs on a monthly basis. We are skeptical, however, that this enrollment limitation alone would accomplish this goal as we outline in more detail below.

We have heard that integrated health plans are concerned that under these proposals, dually eligible individuals will be encouraged to disenroll and re-enroll in integrated plans on a month to month basis and disrupt continuity. We disagree. Dually eligible individuals are unlikely to "shop" for plans on a month to month basis.[27] Enrollees are most likely to change plans when they are experiencing a disruption or cannot access care and should not be prevented from doing so. If individuals are changing plans not to meet their needs, it is likely because of aggressive, and at times, improper marketing. The solution to this problem is stricter and more robust marketing restrictions rather than further complicating enrollment rules. Placing limits on enrollment into integrated plans instead risks disruption and access to care for dual eligibles. We encourage CMS to track and monitor the use of this SEP and evaluate the reasons people are making decisions to change or disenroll from an integrated plan.

As proposed, the two new SEPs—the continuous dual SEP and integrated care SEP—would treat LIS recipients who do not have Medicaid differently than LIS recipients who do have Medicaid. Specifically, LIS recipients without Medicaid would lose their ability to re-enroll in an MA plan on a quarterly basis and would only be able to enroll in an MA plan during the initial, annual, and open election periods. This would impact approximately 1 million LIS recipients. Meanwhile, LIS recipients with Medicaid would be able to re-enroll in an MA plan on a monthly basis, but only if they are enrolling in an integrated MA plan. This proposal is so complex that it requires multiple tables in the proposed rule to describe.

While we recognize this complexity is unavoidable in order to accomplish the policy goal of increasing the percentage of dually eligible individuals receiving care through integrated plans, the new continuous dual SEP will be very difficult to communicate to SHIP counselors, advocates, and Medicare enrollees and lead to confusion about *when* and *whether* an enrollee can change plans. **CMS must make robust investments in education regarding the new SEPs.** This must include measures to ensure Medicare enrollees, their representatives, SHIP counselors, and advocates can quickly ascertain which MA plans are "integrated." This includes, for example, changes to Medicare Plan Finder (as suggested below).

[27] Jeannie Fuglesten Biniek et. al., KFF, "Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment," (Nov. 1, 2022).

2. Enrollment Limitations for Non-Integrated Medicare Advantage Plans

We support CMS's proposal to increase enrollment of dually eligible individuals into D-SNPs with an affiliated Medicaid plan by 1) limiting new enrollment in the D-SNP to individuals enrolled in the affiliated Medicaid plan starting in 2027; and 2) by 2030, requiring these plans to disenroll any individual from the D-SNP who is not also enrolled in the affiliated Medicaid plan. It would undermine integration to continue to allow these integrated plans to serve dually eligible individuals who are not enrolled in their affiliated Medicaid plan. However, this policy raises questions and the need for extensive policy guidance, including policies like California's matching policy as discussed in more detail below, as well as enrollment education and assistance to ensure that Medicare enrollees choices are honored and they do not experience disruptions in care. As also discussed in more detail below, this proposal must be expanded to apply to coordination-only D-SNPs. Otherwise, less integrated care options will continue to proliferate undermining CMS's goals of increasing integrated coverage.

We have the following policy questions regarding the proposed enrollment restrictions for integrated MA plans:

- For ***newly enrolling individuals wanting to join a D-SNP with an affiliated Medicaid plan***, the individual's current Medicaid plan enrollment decision is controlling under this proposal. Yet, Medicaid plan enrollment is often by default and less consequential since dually eligible people are receiving their health care services from Medicare providers and the D-SNP network has a larger impact on their access to care. In states that prohibit disenrollment from a Medicaid managed care plan outside of a 90-day window, this Medicaid choice can prohibit D-SNP enrollment for a year. For individuals who enrolled in a Medicaid plan by default, they would effectively be locked out of the benefits of integration for at least several months.

  CMS should work with states to implement Medicaid plan enrollment policies that allow for disenrollment when an enrollee is electing to enroll in a D-SNP. States should also be providing dually eligible individuals with extensive education regarding their integrated enrollment choices and how their Medicaid plan choice can impact their Medicare enrollment options. States can also implement matching policies in which the Medicare enrollment decision is controlling and individuals are automatically enrolled in the affiliated Medicaid plan. See for example, California's matching policy.[28]

- For ***D-SNP members who are currently enrolled in an unaligned Medicaid plan***, will it be permissible for the D-SNP to contact these members and encourage them to enroll in their affiliated MCO? Will this be a state-specific marketing decision? Where will this guidance be made available?

  If members cannot change their Medicaid plan or choose not to enroll in the affiliated Medicaid plan, CMS should ensure D-SNPs have template letters explaining why the member is being disenrolled from the D-SNP, listing their continuity of care protections, and a clear explanation of how to choose a new MA plan or PDP. The ability to enroll in an integrated D-SNP with an affiliated Medicaid plan is another reason CMS' proposed integrated SEP for dually eligible individuals must permit enrollment and disenrollment in an integrated plan on a monthly basis.

[28] California Department of Health Care Services, "2023 Medi-Cal Matching Plan Policy for Dual Eligible Beneficiaries."

- ***D-SNP members who are currently enrolled in the aligned Medicaid plan but choose to enroll in an unaligned Medicaid plan*** will also be disenrolled. In these instances, CMS should consider guidance to states on how to process these Medicaid plan enrollment changes. In many instances, enrollees do not understand the implications changing their Medicaid plan would have on their Medicare D-SNP choice. Guidance could, for example, require putting in additional safeguards before processing the change to ensure the enrollee understands the impact of the Medicaid plan change on their D-SNP enrollment, including any care coordination or supplemental benefits they are currently receiving from their D-SNP. Under California's matching policy, individuals enrolled in a D-SNP and aligned Medicaid plan who try to change their Medicaid plan, receive a notice informing them that the Medicaid plan change will not be effectuated until they disenroll from the Medicare plan.[29]

We also strongly support CMS's proposal to only contract with one D-SNP with an affiliated Medicaid managed care plan operated by the same MA or parent organization. Except in instances in which these D-SNPs are serving distinct populations (e.g., enrollees under 65 with disabilities or 65 and over; or partial versus full dually eligible individuals), the availability of more than one MA plan operated by the same parent company for individuals dually eligible has little to no benefit for enrollees and creates confusion. Today, the D-SNP landscape presents dually eligible individuals with an overwhelming number of plans to choose from with little to no discernable difference between plan offerings. As CMS notes, requiring the consolidation of D-SNPs would also result in the consolidation of investment and innovation into the single D-SNP.

In a Tampa zip code, for example, there are a total of 85 MA plans available. Of these MA plans, 31 are D-SNPs available to either partial or full dually eligible individuals. Among these, there are a number of D-SNPs available to fully dually eligible individuals operated by the same parent company. Aetna is one of these parent organizations that offers more than one HIDE-SNP to fully dually eligible individuals in the same service area and with an affiliated Medicaid plan. The only discernible difference between Aetna's two HIDE-SNPs is with regard to cost sharing: one plan covers inpatient hospital stays for $0 or $30 per day for days 1 through 4 and $0 per day for days 5 through 90 while the other plan covers $0 or $85 per day for days 1 through 5 and $0 per day for days 6 through 90.[30] This is a difference without meaning since $0 cost sharing applies to all fully dually eligible individuals. Enrollees, their representatives, and SHIP counselors are left wondering whether they are missing something regarding the plans' benefits and at a loss as to which plan to select. In total, there are 82 HIDE-SNPs operating in Florida where the proposed rule would have a significant impact in reducing the complexity in the integrated landscape.

Yet, CMS's proposed rule does not go far enough. For example, the parent organizations operating the 15 coordination-only D-SNPs in Florida would not be subject to this same requirement under the NPRM. Similarly, in Texas, there are 30 coordination-only D-SNPs offered in addition to 35 HIDE SNPs in the same service area. In Louisiana, eight parent organizations are operating 21 coordination-only HMO D-SNPs with most operating more than one D-SNP in the same service area. Humana offers **six** coordination-only HMO D-SNPs in the same service area, including two available statewide.

[29] *Id*.
[30] Author's review of CMS, "SNP Comprehensive Data," (November 2023) and CMS, Medicare Plan Finder.

The experience with D-SNP look-alikes is also a cautionary outcome that should be heeded here. D-SNP look-alikes proliferated because any plan could still receive higher reimbursements for serving people dually eligible, without being subject to the higher regulatory integration requirements of D-SNPs. These same incentives drive parent organizations to establish and maintain coordination-only D-SNPs today without being subject to more stringent care coordination requirements or integrated appeals and grievances designed to better serve the dually eligible population as required in FIDE, HIDE, and Applicable Integrated Plan (AIP) D-SNPs. This is particularly the case in states that do not require enrollment of dually eligible individuals into Medicaid managed care,in states that have not put in place policies advancing integrated care, or states without expertise in Medicare policy. Today, only one state has a dedicated Medicare Coordination Office.[31] Without CMS regulatory action, coordination-only D-SNPs will continue to proliferate. Accordingly, **CMS must limit its contracts to one coordination-only D-SNP operated by the same parent organization in the same service area in order to reduce the choice complexity dually eligible individuals face across the country and promote enrollment in integrated D-SNPs.**

If there are network differences between the D-SNPs being consolidated, CMS should require plans to extend and enter into contracts with all providers of the subsumed D-SNP(s) and establish generous continuity of care policies to minimize disruption.

We also support CMS limiting contracts with parent organizations offering both Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) offerings in the same service area. As we describe in more detail below, we are very skeptical that PPO offerings targeted to dually eligible individuals provide value, but instead primarily serve as a means for plans to increase enrollment.

We also urge CMS to go further than the proposed rule by only contracting with integrated D-SNPs – HIDEs, FIDEs, and AIPs –and not enter into contracts with non-integrated or coordination-only D-SNPs in the same service area. This would have the greatest impact on advancing integration for individuals dually eligible and reducing the complexity of the current landscape of plans available to dually eligible individuals. We recognize that CMS may not have the statutory authority to implement this change under the Bipartisan Budget Act of 2018 and urge further evaluation of this option including supporting legislative change.

D. Comment Solicitation: Medicare Plan Finder and Information on Certain Integrated D–SNPs

We appreciate that CMS is seeking to make improvements to Medicare Plan Finder (MPF) for people dually eligible. Many dually eligible individuals may make enrollment choices unassisted either because they do not know that SHIPs are available or SHIP resources are limited. Improvements to MPF would also assist SHIP counselors, who receive less education regarding Medicaid and integrated options and many of whom are volunteers. We previously submitted comments requesting improvements to MPF with other advocates and interested parties that we incorporate in our comments here.[32]

- **Medicaid benefits available to dually eligible individuals**. We strongly support adding specific Medicaid benefits available to dually eligible individuals regardless of MA plan type - and not just for AIPs. For dually eligible individuals evaluating integrated plans, the value of the

[31] California Department of Health Care Services, "Office of Medicare Innovation and Integration."
[32] Association for Community Affiliated Plans et. al., Letter CMS regarding Medicare Plan Finder, (October 2023).

integrated MA plan (FIDE, HIDE, AIP, and Coordination Only) is the level of integration and supplemental benefits beyond what is covered by Medicaid. Accordingly, for all MA plan types it is critical to list on MPF what enrollees are entitled to under Medicaid so they can effectively evaluate the MA plan on what the plan is offering beyond what they would already be entitled to if they did not enroll.

We recognize that adding Medicaid benefits to MPF creates an additional burden on CMS, states, and MA plans, but this is necessary to accurately reflect the benefits dually eligible individuals are entitled to receive through both the MA plan offerings and Medicaid**.** Otherwise, a dually eligible individual comparing a standard MA plan with D-SNP will conclude they are receiving fewer benefits when in fact they are receiving the benefits through Medicaid and the D-SNP. And as previously stated, enrollees must be empowered to evaluate the D-SNP offering on what it is adding in terms of value compared to remaining enrolled in fee-for-service Medicare or in another MA plan.

We disagree with CMS that carved out Medicaid benefits should be excluded. Whether a benefit is available through Medicaid is determinative – not whether the Medicaid benefit is delivered by the MA plan. If carved out benefits, like transportation or personal care services, are excluded from MPF, dually eligible individuals would come to the same erroneous conclusion as when they are delivered through the D-SNP – that MA plans offering these as supplemental benefits are more robust than a D-SNP.

We recommend that for whichever process CMS chooses to obtain information regarding Medicaid benefits – through the State Medicaid Agency Contract (SMAC) or from D-SNPs directly – that CMS incorporate a review of the accuracy of Medicaid coverage by the state Medicaid agency. This ensures that what is advertised as Medicaid benefits on MPF are accurate.

- **MPF Users should be able to select all the help they receive with costs.** When individuals use MPF, they are asked before starting whether they receive help with costs from Medicaid, SSI, a Medicare Savings Program, or Extra Help from Social Security. Most Medicaid recipients are receiving help from all of these programs. Yet, users can only select one option. This is confusing and can lead users to believe that had they selected a different option they would have different plan options. Users should be able to select all the options available to them.
- **MPF's default display should list D-SNPs first for people who are dually eligible.** Today, MPF's default is to sort plans based on premium price, even for people who are dual-eligible and pay little to no premiums or cost sharing. Instead, we recommend that Plan Finder prioritize D-SNPs by level of integration with Medicaid in the search function for people who are dual eligible.
- **MPF should make clear that users are seeing all available MA plans.** In addition to MPF listing D-SNPs first by integration level, MPF should also inform dually eligible users that they are seeing all available MA plans in their service area, not only D-SNPs.
- **Plan information should include the integration designation.** When MA plans are displayed, the D-SNPs integration designation should be displayed under the plan ID and above the star rating, including FIDE, HIDE, AIP, and Coordination Only. This designation should be hyperlinked

with the definition of the designation in plain language (similar to the hyperlinks currently utilized in MPF for health deductible or drug deductible).

- **Users must be able to filter by integration designation.** To utilize the new duals integration SEP, users must be able to quickly determine which plans they are able to enroll in through the SEP. Accordingly, users should be able to filter plans by AIP, HIDE, and FIDE-SNP designations as well as coordination-only D-SNPs. We recommend adding a specific filter for integration SEP eligible plans. This filter would exclude MA plans that individuals are not eligible to enroll in through the SEP.

- **Costs should accurately reflect the financial assistance dually eligible people receive through Medicaid and Medicare Savings Programs.** If a user selects that they receive help with costs from another program (e.g., Medicaid or a Medicare Savings Program), the costs shown on the plan results page should reflect this help. Today, MPF still includes Part B premiums on the results page despite the fact that those enrolled in Medicaid or a Medicare Savings Program do not pay premiums.

- **My Care My Choice**. The elements of My Care My Choice that would be most valuable for incorporating into MPF are the links and resources to "Understanding my Care" including "What's Covered" under both Medicare and Medicaid and the "Glossary." These resources should be updated to accurately reflect the options for care dual eligibles can receive including PACE, integrated D-SNPs (FIDE, HIDE, AIPs), ACOs, and original Medicare.

  Other elements of My Care My Choice oversimply choice selection in light of the complexity of enrollment options and variation in options and Medicaid coverage across states. My Care My Choice also presents enrollment in MA plans as the better or preferred option, when this is not the better option for many dually eligible enrollees. Resources would be better employed through investments in SHIPs to provide individualized counseling and establish an ombuds program.

E. Comment Solicitation: State Enrollment Vendors and Enrollment in Integrated D–SNPs

1. Current Opportunity for Use of State Enrollment Vendors for Enrollment in Integrated D–SNPs

We agree that state enrollment vendors can be beneficial in mitigating enrollment in misaligned Medicaid plans and in enrollment dates and providing unbiased information regarding coverage options and enrollment. However, we encourage caution and robust oversight if CMS decides to permit states to use enrollment vendors to enroll individuals dually eligible into D-SNPs. During the Financial Alignment Initiative, state enrollment vendors were required to complete extensive training, and they still routinely made serious enrollment errors and provided inaccurate information. While state enrollment vendors can play a key role in simplifying enrollment processes for states, they cannot do so at the expense of dually eligible individuals by providing inaccurate information or committing enrollment errors that do not honor a person's choice. Furthermore, if CMS moves in this direction, CMS should reevaluate its marketing guidelines for D-SNPs and determine how enrollment transactions normally conducted by the D-SNP would be processed.

2. Medicaid Managed Care Enrollment Cut-Off Dates

We appreciate that CMS is seeking comment on whether to align Medicare enrollment and Medicaid managed care enrollment completely in the context of the integrated SEP. Justice in Aging recommends retaining the current policy. We acknowledge the real confusion and disadvantages that misaligned enrollment dates present but believe these obstacles do not outweigh the benefits of the current policy. If enrollment dates are aligned, dually eligible individuals may have fewer integrated SEP options available to them. We also believe that the harm from misaligned enrollment dates today is mitigated by the fact that most individuals make their enrollment choices prior to the Medicaid enrollment cutoff dates. In states in which cut-off dates vary each month (like in California), it would be very difficult to communicate to enrollees when their Medicare plan enrollment would become effective. We suggest that CMS work with states, SHIPs, D-SNPs, agents and brokers, and enrollment vendors to clearly convey effective enrollment dates.

3. Comment Solicitation

Justice in Aging submits the following responses to the following questions at FR 78578.

- **What challenges do duals face when trying to enroll in integrated D-SNPs?** Enrollees today face an information overload of plan options, they must analyze supplemental plan benefits versus what is already available to them through Medicaid, and understand the value of care coordination. Dually eligible individuals also experience an onslaught of marketing through high volumes of mail, TV advertisements, internet pop ups, all on top of communication from their current health plans and notices and materials from their Medicaid programs and other public benefit programs. Individuals report challenges with finding trusted and unbiased sources to get information, difficulties with "overwhelming" and "laborious" materials, and difficulties finding written materials that are targeted to them specifically as individuals and which explain their options so they can make informed decisions.[33]

- **What concerns would stakeholders have if CMS used flexibilities to change the Medicare effective date in context of proposed SEP for integrated care?** Changing the Medicare effective date would upend common knowledge regarding enrollment effective dates that apply to special needs plans and Medicare-Medicaid plans under the FAI. Instituting a different enrollment date for this specific SEP would result in confusion regarding a person's coverage status and where to bill covered services. Changing the Medicare effective date could also act to limit the number of SEPs an individual has available. If an individual made an integrated Medicare plan choice that did not take effect until the 2nd month following their plan choice, they have one less month to use the integrated SEP in that year. Individuals in this scenario may also choose to make another integrated choice in the gap month, not realizing their original plan enrollment choice was not yet effective. This could lead to even more confusion about enrollment status and claims coverage.

- **Other aspects of the integrated enrollment and disenrollment processes in FAI that should apply to DSNPs?** Disenrollments from D-SNPs should align with FAI dates and individuals should

[33] Siena Ruggeri, Community Catalyst, "Policy Options to Create a Person Centered Enrollment Infrastructure for Medicare-Medicaid Enrollees," (July 2023).

have until the last calendar day of the month to request disenrollment with the effective date being the first day of the following month.

G. Contracting Standards for Dual Eligible Special Needs Plan Look-Alikes (§ 422.514)

We strongly support CMS's proposal to lower the D-SNP look-alike threshold over a two-year period. We however, **urge CMS to lower the threshold from 80% to 50%.** As we previously commented, we believe that a 50% threshold will be a more effective threshold for deterring MA plans from soliciting dually eligible individuals into non D-SNPs. Per CMS's analysis, only one county or service area has a percentage of more than 49% of individuals dually eligible, for which CMS could offer an exception. Today, D-SNP look-alikes continue to grow and are drawing dual eligibles away from integrated options.[34] Even more troubling, D-SNP look-alikes are more likely to enroll individuals who are Hispanic, live in a rural area, and are residing in the most socially vulnerable communities.[35] Lowering the threshold will help to simplify plan options for all Medicare enrollees by reducing duplicative plan offerings, and reduce the extent (and misleading) marketing targeted at dually eligible individuals.

We believe that the disruption caused by lowering the threshold is mitigated because many of the parent organizations of these plans were subject to the prior look-alike threshold change and will have the processes in place to effectuate the new changes. CMS should provide additional resources to plans that were not previously subject to the threshold change.

We also support CMS' proposal to limit the transition options available to identified D-SNP look-alikes in 2027 at 422.514(e). After year 2027, D-SNP look-alikes can only use 422.514(e) to transition their dually eligible enrollees into a D-SNP and not a traditional MA plan. Eliminating the traditional MA option will immediately reduce incentives to transfer dually eligible individuals into a Medicare Advantage plan, that in future years may reach the D-SNP look-alike threshold. We believe these two policies, limiting the transition processes available to MA plan sponsors that operate look-alikes and further reducing the threshold, in combination will reduce the continued proliferation of D-SNP look-alikes.

H. For D-SNP PPOs, Limit Out-of-Network Cost Sharing (§ 422.100)

Justice in Aging strongly supports CMS's proposal to require D-SNP PPOs to cap their cost-sharing for specific services. We are very skeptical that PPO D-SNP offerings are resulting in a more expansive network of providers for enrollees today. In fact, it is likely that PPO offerings with the promise of higher cost sharing is compounding the impact of the "lesser of" policy which already acts to deter providers from serving dually eligible populations because they are not fully reimbursed by Medicaid. The high cost sharing amounts also increase the likelihood for improper billing at higher amounts. CMS's proposal to cap cost sharing would set expectations for payment that are aligned with cost sharing protections for dually eligible people. **We ask CMS to implement this policy in plan year 2025 rather than 2026 considering the negative impact it has on dually eligible enrollees and state budgets**.

We note, however, that this problem remains for non-D-SNP PPOs in which individuals dually eligible are enrolled. There are almost as many dually eligible people enrolled in non-D-SNP PPOs (827,318) as there

[34] Yanlei Ma et. al., "Rapid Enrollment Growth in 'Look-Alike' Dual-Eligible Special Needs Plans: A Threat to Integrated Care," Health Affairs 42(7) (July 2023).
[35] *Id*.

are in D-SNP PPOs (906,616).[36] We are hopeful that the proposals to advance integration in this NPRM will reduce enrollment in these non-integrated MA plans. We continue to urge CMS to also work with states to limit their "lesser of" policies.

Beyond this proposal and its limitations, we remain skeptical that PPO D-SNPs offer value to enrollees. Out-of-network providers can refuse to see dually eligible individuals since they are not contracted with the D-SNP. Meanwhile, HMO contracted providers are required to serve dually eligible individuals since they are contractually prohibited from discriminating on the basis of payer source. We encourage CMS to evaluate these PPO offerings and whether enrollees are meaningfully accessing out-of-network providers. The addition of PPO D-SNPs increases the number of plan options available and the complex landscape of plans dually eligible individuals have to navigate. It should be clear these plans are actually improving access for enrollees and not just a means of increasing reimbursement and the plan's profit.

Conclusion

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please feel free to contact me at achrist@justiceinaging.org.

Sincerely,

Amber C. Christ
Managing Director, Health Advocacy

[36] ATI Advisory analysis of PPO enrollment (Jan. 3, 2024).