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January 5, 2023

VIA ELECTRONIC SUBMISSION

Hon. Chiquita Brooks-LaSure  
Administrator, Centers for Medicare & Medicaid Services  
Attention: CMS-4205-P  
P.O. Box 8013  
Baltimore, MD 21244

**Re: RIN 0938-AV24**

**Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications [CMS-4205-P]**

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly** proposed rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

Every year, thousands of people with Medicare and their families contact our national helpline with questions about how Medicare works, how to choose their coverage pathway, how their Medicare Advantage (MA) or Part D plan works, what are the limitations of such plans, and what to do if they encounter problems.

**II. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies: Past Performance**

Intermediate sanctions are a basis for denial of an application from an MA organization or Part D sponsor. To clarify the basis for application denials due to past performance in regard to intermediate

sanctions, CMS proposes to change the wording of the regulation from “Was subject to the imposition of an intermediate sanction” to “Was under an intermediate sanction” to reflect stated intent to deny applications from MA organizations and Part D sponsors when an active sanction existed during the relevant 12-month review period. We support this clarifying change.

### **III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs**

#### **A. Expanding Network Adequacy Requirements for Behavioral Health**

CMS proposes to add “Outpatient Behavioral Health” as a facility specialty type evaluated as part of network adequacy reviews. This specialty type can include Marriage and Family Therapists (MFTs), Mental Health Counselors (MHCs), Opioid Treatment Program (OTP) providers, Community Mental Health Centers or other behavioral health and addiction medicine specialists and facilities. We support this additional requirement. However, we recommend CMS require tracking of this facility type by separately reporting metrics for “Outpatient Mental Health” (MH) and “Outpatient Substance Use Disorder” (SUD) providers, rather than a combined category. By Collapsing MH and SUD facilities into one category, CMS allows plans to mask any limitations in SUD provider availability that exceed MH. As this proposed rule is written, an MA plan could contract exclusively with MHCs and MFTs to meet the proposed network adequacy standards without having any OTPs or SUD providers in network.

In addition, we also strongly urge CMS to shorten the maximum time and distance standards for these providers to align with those for qualified health plans.<sup>1</sup>

#### **D. Improvements to Drug Management Programs**

##### **1. Definition of Exempted Beneficiary**

CMS proposes to amend the regulatory definition of “exempted beneficiary” at § 423.100 by replacing the reference to “active cancer-related pain” with “cancer related pain” to expand the definition of exempted beneficiary to more broadly refer to enrollees being treated for cancer-related pain to include beneficiaries undergoing active cancer treatment, as well as cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance only. We support this change.

##### **2. Drug Management Program Notices: Timing and exceptions**

CMS proposes to specify that, for such exempted beneficiaries, the sponsor must provide the alternate second notice within 3 days of determining the beneficiary is exempt, even if that occurs less than 30 days from the date of the initial notice. We support this change.

#### **G. Parallel Marketing and Enrollment Sanctions Following a Contract**

CMS proposes to state that the marketing and enrollment sanctions will go into effect 15 days after CMS issues a contract termination notice. This timeframe is consistent with the number of days CMS often

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<sup>1</sup> Centers for Medicare & Medicaid Services, “2023 Final Letter to Issuers in the Federally-facilitated Exchanges” (April 28, 2022), <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>.

designates as the effective date for sanctions after CMS issues a sanction notice. In addition, CMS proposes that the sanction would remain in effect until the effective date of the termination, or if the termination decision is overturned on appeal, until the final decision to overturn the termination is made by the hearing officer or Administrator. We support these changes.

#### **H. Update to the Multi-Language Insert Regulation**

The multi-language insert (MLI) is a standardized communication material that informs Medicare enrollees and prospective enrollees that interpreter services are available in the 15 most common non-English languages in the United States. Medicare plans are also required to translate the MLI into any non-English language primarily spoken by least 5% of the individuals in the plan's service area. They have the option to make it available in languages that do not meet the 5% threshold. To better align these requirements with existing Medicaid translation standards and draft rules for ACA plans, CMS proposes to require that MA and Part D plans provide a Notice of Availability of language assistance services and auxiliary aids and services in English and at least the 15 most commonly spoken languages by individuals with limited English proficiency of the relevant State, as well as in alternate formats for individuals with disabilities to ensure effective communication. Additionally, CMS proposes to require the Notice of Availability to be translated into additional languages that meet the 5% service area threshold. We strongly support these proposals.

#### **I. Expanding Permissible Data Use and Data Disclosure for MA Encounter Data**

CMS proposes to allow MA encounter data to be used to support the Medicaid program for certain purposes already specified for use to support the Medicare program. In addition, CMS proposes to allow the release of MA encounter data to State Medicaid agencies (States) in advance of the completion of risk adjustment reconciliation for the specific purpose of care coordination for individuals who are dually eligible for Medicare and Medicaid, also known as dually eligible individuals. We support these changes.

#### **J. Standardize the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Appeals Process**

CMS proposes to require that MA organizations must exhaust all levels of appeal for medical record review determinations before the payment error calculation appeals process can begin. We support this change to standardize the RADV appeals process and reduce the applicability of interlocutory appeals.

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

#### **B. Evidence as to Whether a Special Supplemental Benefit for the Chronically Ill (SSBCI) Has a Reasonable Expectation of Improving the Health or Overall Function of an Enrollee**

Currently, the burden is on CMS to review SSBCI included in an MA organization's bid and determine whether sufficient evidence or data exists to demonstrate that it has a "reasonable expectation" of improving or maintaining the health or overall function of a chronically ill enrollee. CMS proposes to shift this responsibility—for identifying supporting evidence or data to support an SSBCI and to establish compliance with the applicable law—onto the MA organization that is seeking to offer the benefit. This would include (1) requiring the MA organization to establish, by the date on which it submits its bid, a bibliography of "relevant acceptable evidence" related to the item or service the MA organization would

offer as an SSBCI during the applicable coverage year; (2) requiring that an MA plan follow its written policies (that must be based on objective criteria) for determining eligibility for an SSBCI when making such determinations; (3) requiring the MA plan to document denials of SSBCI eligibility rather than approvals; and (4) codifying CMS’s authority to decline to accept a bid due to the SSBCI the MA organization includes in its bid and to review SSBCI offerings annually for compliance, taking into account the evidence available at the time. We strongly support these changes, which would better ensure regulatory goals are met, as well as promote better program transparency and oversight. Accordingly, we urge CMS to apply these requirements to all SSBCI.

We strongly encourage CMS to require that MA plans make these written policies available to not only the agency, but also to the public via their websites and other means as appropriate. Doing so would help providers, beneficiaries, and counselors know in advance of any enrollment or care decisions what the applicable SSBCI criteria are, as well as the scope of the benefit’s availability in general and with respect to the individual beneficiary. In the event of a denial, this public-facing information could improve timely appeals by facilitating resolution at the lowest possible level, reducing burdens on all involved.

We reiterate our concerns that SSBCI have not been extended to the majority of Medicare enrollees—individuals who choose Original Medicare—and that they remain limited in both availability and accessibility within MA, as does utilization and other data. We urge CMS to strengthen transparency and data collection, and to support expanding equitable access to SSBCI to all Medicare enrollees through both legislation and administrative means, such as CMMI demonstrations.

### **C. Mid-Year Notice of Unused Supplemental Benefits**

In our experience, many people sign up for MA plans in part due to the marketing of supplemental benefits, but the enrollees may not use these benefits for many reasons, including not knowing about them, forgetting them, not knowing how to access them, and other circumstances. In 2022, supplemental benefits were the most common reason enrollees cited for choosing an MA plan over Original Medicare,<sup>2</sup> despite an alarming lack of data on their utilization, quality, and value.<sup>3</sup>

We appreciate that CMS recognizes these benefits are often going unused. In this context, CMS proposes to require that MA organizations mail a mid-year model notice annually (not sooner than June 30 and not later than July 31 of the plan year) to each enrollee, with information pertaining to the supplemental benefits available during that plan year that the enrollee has not begun to use. While we consider a mid-year notice better than nothing, we would more strongly support more frequent, quarterly notices.

CMS specifically seeks comment on the timing of the notice for beneficiaries who have an enrollment effective date after January 1. One possible approach CMS is considering is to require plans to send the notice six months after the effective dates in the individual’s first year of enrollment, and between the

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<sup>2</sup> Faith Leonard, *et al.*, “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why,” The Commonwealth Fund (October 17, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.

<sup>3</sup> Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress” (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).

proposed delivery dates of June 30 and July 31 in subsequent years. We are concerned this pattern would not provide some enrollees—such as those who would receive notification with only a few weeks remaining in the plan year—with enough time to access their unused benefits. In the absence of requiring a standard quarterly notice, at a minimum, we recommend the adoption of a sliding date range for notice delivery, based on the amount of time remaining in the plan year after the individual’s enrollment start date, perhaps half of the remaining months.

Another option CMS is considering is to not require plans to mail the notice for the first year of enrollment for those beneficiaries with an effective date of May 1 or later. We do not support this option as it would arbitrarily prevent these enrollees from obtaining information that could improve their health and well-being.

CMS also proposes to require MA organizations to list in the notices information about each applicable benefit that appears in the enrollee’s Evidence of Coverage (EOC). This would include all covered mandatory supplemental benefits and optional supplemental benefits the enrollee has elected, is eligible for, but has not accessed. For SSBCI, MA organizations would be required to include an explanation of the covered item or service (including eligibility criteria, limitations, and scope) as well as point-of-contact information. This could be a customer service line or a separate dedicated line, with trained staff available to answer enrollee questions about SSBCI access and eligibility.

#### **D. Annual Health Equity Analysis of Utilization Management Policies and Procedures**

We appreciate CMS’s continued attention to prior authorization and other utilization management (UM) strategies. In our experience, these practices often yield harmful coverage denials that force beneficiaries to choose between seeking other care, paying out-of-pocket, or going without—or getting embroiled in a daunting appeals system. We hear from many enrollees who don’t know where or how to begin, as well as from those who can’t; they simply don’t have time to wait for treatment or to wade through what might be a thicket of denials across their care.

Importantly, even successful appeals come at a cost. While the most significant risks are care delays and negative health outcomes, they are also burdensome for beneficiary and provider alike, creating strain, expense, and extra work. Many beneficiaries abandon the process altogether, along with the care they need. And when plans systematically and inappropriately deny claims, it may have a chilling effect on providers’ willingness to prescribe or provide a treatment or cause providers to spend additional time and resources “over proving” claims to avoid denials.

Appeals are a necessary safety valve and important quality marker, but currently function as a very poor substitute for sound plan decisions and robust independent oversight. Both the denials that unnecessarily force people into a broken appeals system, and that system itself, must be addressed.

For these reasons, we urge a parallel focus on bettering UM processes and simplifying appeals systems, including improving plan communications with enrollees. When plans issue a denial, they are required to notify the affected enrollee in a timely manner, and this notification should contain everything the enrollee needs to determine next steps, which may involve pursuing an appeal. Despite the importance

of this obligation, many plans fail to comply.<sup>4</sup> CMS must do more to make sure plan notices are correct, promptly delivered, available in languages other than English, and accessible in a range of formats and to people with varying levels of health literacy. We also support invalidating and immediately escalating coverage denials that were not accompanied by proper notice.

As discussed throughout, to enhance data collection and reporting efforts, we ask CMS to monitor MA coverage and care decisions for high denial and overturn rates as well as for low appeal rates, and for patterns therein, like inappropriate denials for specific services or categories of care. Any trends that emerge should trigger a more comprehensive review to determine the underlying cause of the error and to obligate the plan to resolve it. Plans that regularly engage in such practices should lose the ability to enroll new members or, if the violations are severe, to contract with CMS, until corrections are made and publicly documented. Offending plans should remain subject to higher levels of review going forward and all captured data should be made publicly available. Finally, to best obtain the full range of data about pre- and post-service denials, we ask the agency to rescind the September 2020 guidance improperly limiting reported elements.<sup>5</sup>

Ultimately, MA plans that inappropriately deny care must not be permitted to benefit from it. Capitation provides a motive to deny or delay access to care, but penalties for bad actors can help reduce the force of this incentive. Or, if the decisions are simply mistakes, corrective actions from CMS can spur plans to take more care in their process design and decision-making.

We recognize that CMS has taken steps to improve plan UM administration and oversight. In April 2023, CMS finalized a requirement that all MA organizations using UM policies and procedures establish a UM committee to review and approve those initiatives at least annually, and to ensure consistency with Original Medicare's national and local coverage decisions as well as with relevant Medicare rules.

CMS now seeks to add health equity-related component to the UM committee structure. In introducing this proposal, the agency importantly notes that examining UM policies "from a health equity perspective is an important beneficiary protection" and that "such an analysis may assist in ensuring that MA plan designs do not deny, limit, or condition the coverage or provision of benefits on a prohibited basis (such as a disability) and are not likely to substantially discourage enrollment by certain MA eligible individuals with the organization." We applaud these goals.

Under the proposed rule, beginning January 1, 2025, UM committees would be required to include at least one member with "health equity expertise," such as "educational degrees or credentials with an emphasis on health equity, experience conducting studies identifying disparities amongst different population groups, experience leading organization-wide policies, programs, or services to achieve health equity, or experience leading advocacy efforts to achieve health equity." We support the addition

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<sup>4</sup> In 2015, 45% of Medicare Advantage plans sent denial letters with incomplete or incorrect information. See HHS Office of Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials" (September 2018), <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>.

<sup>5</sup> Centers for Medicare & Medicaid Services, "Revised Appeal and Grievance Data Form, Form CMS-R-0282," (September 24, 2020), <https://www.hhs.gov/guidance/document/revised-appeal-and-grievance-data-form-form-cms-r-0282>. (Removed the following data elements from the standardized Appeal and Grievance Data Form [Form CMS-R-0282] Expedited appeals; Disposition of expedited appeals, IRE (level 2) appeals, Disposition of IRE (level 2) appeals, Withdrawals).

of committee members with expertise in health equity. Whatever the definition for expertise is to be, we urge CMS to issue clear explanatory guidelines to ensure plan compliance and limit opportunities for misaligned or bad faith interpretations.

CMS also proposes to require UM committees to conduct annual health equity analyses on the use of prior authorization, with such analysis to be approved by the committee member(s) with health equity expertise before it is publicly posted on the plan's website. The proposed report would examine the impact of prior authorization at the plan level, on enrollees with one or more of the following social risk factors (SRF): (1) receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid (LIS/DE); or (2) having a disability. We support this proposal and recommend that the SRF categories additionally include members of racial and ethnic communities; members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community; individuals with limited English proficiency; members of rural communities; persons otherwise adversely affected by persistent poverty or inequality; formerly incarcerated individuals; veterans; and individuals experiencing homelessness.

The analysis would compare enrollees with and without SRFs on several metrics related to the use of prior authorization. We strongly support this approach, as well as the proposed data collection points:

- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, aggregated for all items and services.

We strongly urge CMS to increase publicly reported metrics around appeals, including the number of appeals and breakdowns of overturned denials by items and services and at each level of appeal.

CMS proposes to require the health equity analysis be posted on the plan's publicly available website in a prominent manner, clearly identified in the footer of the website, easily accessible to the general public without barriers like cost, accounts, passwords, or the collection of personal data. We support these proposals.

CMS is considering adding a requirement that UM committees submit to CMS the link to the analysis report, allowing CMS to post every link in one centralized location. We strongly support this common-sense update.

CMS also requests comment on any specific items or services, or groups of items or services, subject to prior authorization that should additionally be disaggregated in the analysis. We recommend that CMS also require this level of detail for mental health and substance use disorder treatment.

## **V. Enrollment and Appeals**

### **A. Revise Initial Coverage Election Period Timeframe to Coordinate with A/B Enrollment**

Currently, the Initial Coverage Election Period (ICEP) begins three months immediately before a beneficiary's entitlement to Medicare Part A and enrollment in Part B and ends on the later of (1) The last day of the month preceding entitlement to Part A and enrollment in Part B, or (2) The last day of their Initial Enrollment Period (IEP).

CMS proposes to extend the ICEP for two months after the month in which the beneficiary is first entitled to Part A and enrolled in Part B, providing more flexibility to those who do not enroll in Part B during their IEP. This shift would align the ICEP with other existing SEP-MA timeframes, including the allowance for individuals to enroll in an MA plan when they obtain Part A and/or Part B using the BENES Act's exceptional circumstances SEP.

We support this change. To further improve beneficiary decision-making, we urge CMS to simplify the enrollment and plan selection processes—including by modernizing consumer tools, notifying people approaching Medicare eligibility about enrollment rules and timelines, and ensuring agency communications clearly explain the trade-offs between Original Medicare and MA.

### **B. Enhance Enrollees' Right to Appeal an MA Plan's Decision to Terminate Coverage for Non-Hospital Provider Services**

CMS proposes to (1) require the Quality Improvement Organization (QIO), instead of the MA plan, to review untimely fast-track appeals of an MA plan's decision to terminate services in a Home Health Agency (HHA), Comprehensive Outpatient Rehabilitation Facility (CORF), or Skilled Nursing Facility (SNF); and (2) allow enrollees the right to appeal the decision to terminate services after leaving a SNF or otherwise ending covered care before the planned termination date. We support these changes.

### **C. Amendments to Part C and Part D Reporting Requirements**

CMS proposes to clarify regulations about MA and Part D plan reporting and data collection requirements, including on plan procedures related to coverage, utilization in the aggregate, and beneficiary-level utilization, as well as the steps beneficiaries may need to take to access covered benefits. We support this clarification and urge CMS to act upon the collected data by strengthening oversight, enforcement, and transparency to ensure beneficiaries have meaningful access to care.

## **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)

Regulation of plan marketing and communication on SSBCI has long needed strengthening. Despite recent changes, current plan guardrails are largely limited to a disclaimer requirement that first took effect in January 2022.<sup>6</sup> Under this policy, MA organizations must provide beneficiaries with information about the limitations of SSBCI when discussing those benefits. These disclaimers must: (i) convey that the benefits mentioned are a part of special supplemental benefits, (ii) convey that not all members will qualify for these benefits; and (iii) include the model content in the material copy which mentions SSBCI benefits.

CMS notes this policy is intended to reduce “beneficiary confusion or misunderstanding of the scope of SSBCI, and thus [lessen] the chance that a beneficiary will enroll in a certain plan believing they can access that plan’s SSBCI for which they may not ultimately be eligible.” However, its efficacy is limited, as plan marketing—a core driver of beneficiary misinformation—continues to thwart informed decision-making.

In the nearly two years since this policy took effect, MA plan ads, phone calls, mail, and other solicitations have remained confusing and overwhelming for many beneficiaries.<sup>7</sup> This is especially true during initial and annual enrollment periods. Comparing one’s coverage options is complex enough; prolific and unreliable outreach further complicates these evaluations. For 2024, the average beneficiary had access to 43 MA plans, over twice as many as in 2018.<sup>8</sup> Plans can differ on everything from costs to coverage, making detailed analysis both critical and difficult. This can lead to poor or no decisions, which in turn can have serious consequences like higher costs and lack of access to care.<sup>9</sup> Inaccurate and aggressive marketing makes coverage decisions harder and negative outcomes more likely.

We appreciate that CMS recognizes the need for further reform. In particular, CMS proposes to strengthen the disclaimer by requiring MA organizations to list the chronic condition or conditions the enrollee must have to be eligible for the SSBCI. As outlined, if the number of condition(s) were five or fewer, the SSBCI disclaimer must list all condition(s), and if the conditions number six or more, the SSBCI disclaimer must list the top five conditions, as determined by the MA organization. CMS proposes that the MA organization could choose which five conditions to include, at their discretion. While we support the requirement to list the conditions, we oppose giving such deference to the MA organizations. We urge CMS to be more prescriptive, to identify a metric for organizations to use to determine what conditions would constitute such a “top five,” or, in the alternative, that the organization be required to list all the applicable conditions.

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<sup>6</sup> 87 Fed. Reg. 27704.

<sup>7</sup> KFF, “Marketing Private Medicare Plans” (last visited January 4, 2024), <https://www.kff.org/marketing-medicare/>; Gretchen Jacobson, *et al.*, “The Private Plan Pitch: Seniors’ Experiences with Medicare Marketing and Advertising” The Commonwealth Fund (September 12, 2023), <https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/private-plan-pitch-seniors-experiences-medicare-marketing-advertising>; U.S. Senate Committee on Finance, “Hearing: Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences” (October 18, 2023), <https://www.finance.senate.gov/hearings/medicare-advantage-annual-enrollment-cracking-down-on-deceptive-practices-and-improving-senior-experiences>.

<sup>8</sup> Meredith Freed, *et al.*, “Medicare Advantage 2024 Spotlight: First Look” KFF (November 15, 2023), <https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/>.

<sup>9</sup> Medicare Rights Center, “New Analyses Show Limits of Beneficiary Shopping for Coverage” (November 17, 2022), <https://www.medicarerights.org/medicare-watch/2022/11/17/new-analyses-show-limits-of-beneficiary-shopping-for-coverage>.

CMS proposes to require that the MA organization must convey in its SSBCI disclaimer that even if the enrollee has a listed chronic condition, the enrollee may not receive the benefit as other criteria will also need to be met. We strongly support this proposal.

In addition, CMS proposes specific formatting requirements for font and reading pace that would apply to SSBCI disclaimers in any type of ad, whether marketing or communications. We support the outlined formatting requirements.

CMS proposes to clarify that MA organizations must include the SSBCI disclaimer in all marketing and communications materials that mention SSBCI. We support this update.

To best promote informed beneficiary decision-making, we additionally urge CMS to require plans to include other information in the disclaimer about SSBCI access as well as about general MA access to care, including network and utilization management hurdles that MA plans might have in place for all or some benefits. Enrollees need more accurate and actionable information about the trade-offs between OM and MA before they make these critical enrollment decisions.

Further, while the disclaimer is important, we note that CMS has not established clear rules about how MA plans and brokers may market supplemental benefits to current or potential enrollees. According to a recent Commonwealth Fund analysis, 24% of those who opted for MA were drawn by the extra benefits.<sup>10</sup> Yet, little marketing oversight exists. We urge CMS to rectify this and reinforce that supplemental benefits should not be a sales tool or used to persuade beneficiaries to enroll in a plan. We also ask the agency to be vigilant in its enforcement of existing rules, including by watching for unusual spikes in enrollment and other patterns that might indicate inappropriate behavior. When identified, such practices must be corrected, including through plan and broker penalties and enrollment remedies such as Special Enrollment Periods.

For marketing modernizations to be maximally effective, CMS must also address a complementary barrier to informed beneficiary decision-making: the cluttered plan landscape. Recent rule changes, such as the elimination of meaningful difference and uniformity requirements, as well as reduced network adequacy standards and booming profits, has led to an influx of plans, with single sponsors often offering multiple plans in a given area.<sup>11</sup> Identifying and simultaneously comparing each plan deviation, year after year, is a challenging, intimidating, and time-consuming task that few people with Medicare perform.<sup>12</sup> Instead, they may rely on heuristics like where their neighbors or friends get coverage. Worse, they may rely on marketing that is designed to lure them with promises of benefits they may not be eligible for or that may be so limited as to be essentially worthless.

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<sup>10</sup> Faith Leonard, *et al.*, "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" KFF (October 17, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.

<sup>11</sup> Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress" (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).

<sup>12</sup> See, e.g., Meredith Freed, *et al.*, "More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually" KFF (October 29, 2020), <https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/>; Wyatt Korma, *et al.*, "Seven in Ten Medicare Beneficiaries Did Not Compare Plans Past Open Enrollment Period" KFF (October 13, 2021), <https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/>.

Careful analysis of seemingly endless plan designs may be particularly burdensome for consumers with limited English proficiency, those who have cognitive impairments or other serious health needs, and people with inadequate internet access. Despite the severe consequences of making a poor plan choice—such as high costs, restricted provider access, and delayed care—there are few remedies. If an enrollee makes a mistake, they may be stuck in a plan that does not meet their needs for up to a year or locked into MA indefinitely because of the high cost of Medigap coverage.

Standardization, with only high-quality options, removes some of this complexity and risk. There is precedent for such an approach. Medigap plans are standardized to facilitate comparison, and CMS is beginning to address plan overload in Marketplace coverage, including by offering standardized plans and increased discussion of meaningful differences between plans.<sup>13</sup> We urge similar consideration in the MA space.

In addition to easing plan evaluations, offering standardized plans would advance equity by making it easier for CMS, consumers, advocates, and researchers to identify and prevent discriminatory benefit designs, such as plans that leave individuals with particular conditions or medication needs with substantial out-of-pocket costs.

## **B. Agent Broker Compensation**

Commonwealth Fund analysis also found that most people who received help choosing between their coverage options turned to brokers and agents.<sup>14</sup> But these representatives are not always objective; they receive commissions and other payments which may drive problematic behaviors—including predatory marketing, inappropriate steering, and fraudulent activities—that undermine beneficiary health, safety, and well-being.<sup>15</sup>

We appreciate CMS's acknowledgement that shifting industry dynamics and evolving financial incentives must be addressed if the agency is to comply with its statutory obligation "to ensure compensation paid to agents and brokers incentivizes them to enroll individuals in the MA plan that is intended to best meet their health care needs."

CMS specifically requests comments regarding how it can further ensure that payments made by MA plans to field marketing organizations (FMOs)—a type of Third Party Marketing Organization (TPMO) that employs agents and brokers to complete MA enrollment activities and may also conduct additional marketing activities on behalf of MA plans, such as lead generating and advertising—do not undercut the intended outcome of the agent and broker compensation proposals included herein. We applaud this consideration, as the current environment financially rewards workarounds. We urge oversight of and data collection from MA organizations about total compensation to brokers, agents, FMOs, and other TPMOs to track potential upticks in spending unaccounted for by the proposed rule changes. We

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<sup>13</sup> Centers for Medicare & Medicaid Services, "HHS Notice of Benefit and Payment Parameters for 2024 Proposed Rule" (December 12, 2022), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-proposed-rule>.

<sup>14</sup> *Id.*

<sup>15</sup> Riaz Ali and Lesley Hellow, "Agent Commissions in Medicare and the Impact on Beneficiary Choice" The Commonwealth Fund (October 12, 2021), <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>.

also urge the collection of complete data from agents, brokers, and other applicable entities to ensure all plan payments, direct or indirect, are accounted for.

Relatedly, we also continue to urge CMS to adopt a proposal from the 2024 proposed rule that would bar TPMOs from distributing beneficiary data to other TPMOs.<sup>16</sup> Such a provision would lessen the overwhelming marketing push beneficiaries feel every fall while bolstering the privacy of their personal information and undercutting the power of lead generating FMOs.

### **1. Limitation on Contract Terms**

CMS proposes to require that MA organizations ensure their contracts with agents, brokers, and TPMOs do not create any incentives that would reasonably be expected to inhibit those entities' ability to objectively assess and recommend which plan best meets the health care needs of a beneficiary. CMS notes that among the anti-competitive contract terms it intends to prohibit with this policy are efforts to make renewals or other outcomes dependent on preferentially higher rates of enrollment. We strongly support this proposal.

We also have heard of arrangements in which providers channel some of their value-based payments to agents, brokers, and TPMOs to encourage them to spur enrollment into certain MA plans—namely, those that pay providers at higher rates, generally as a result of the underlying value-based arrangements. Because of this, we encourage CMS to require contract terms that limit the ability of providers to pay these bounties or, if this cannot be achieved through MA contracts, we encourage CMS to directly bar provider compensation to brokers through those providers' conditions of participation in Medicare. At minimum, these payments must be captured in provider, plan and broker / TPMO reporting.

### **2. Compensation Rates**

We share CMS's concern that the lack of a uniform compensation standard creates strong financial incentives for agents and brokers to favor some plans over others, which can ultimately leave beneficiaries with coverage that does not meet their needs.

To begin to address this, CMS proposes to better standardize rates by requiring that all payments to agents and brokers that are tied to enrollment, related to an enrollment in an MA plan or product, or are for services conducted as part of the relationship associated with enrollment into an MA plan or product be included under "compensation." This rate would also include administrative payments. We support this change. The current system allows MA organizations to easily skirt compensation caps through misleading labeling of expenditures.

CMS additionally proposes that the set rates would be paid by all plans. Under this approach, agents and brokers would be paid the same amount either by the MA plan directly or by an FMO. We cautiously support this plan, though we have concerns. If smaller MA organizations are currently paying under the maximum, and if this set of proposals raises that maximum rate, those smaller organizations may face

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<sup>16</sup> Medicare Rights Center, "Comments on Proposed Changes to Medicare Advantage and Part D for Contract Year 2024" (February 13, 2023), <https://www.medicarerights.org/pdf/021323-comments-2024-ma-and-partd-rule.pdf>

increased and unsustainable spending. We urge CMS to thoughtfully consider what the current compensation rates are for smaller MA organizations and to assess whether requiring higher commissions from these plans levels or further skews the playing field.

We recognize the policy, if implemented as intended, may negate the need for annual plan reporting on the specific rates paid to independent agents and brokers. However, assuming such an implementation is premature. We urge CMS to instead collect payment and other data as necessary to ensure plan compliance.

In addition, we urge CMS to contemplate the potential perverse incentives of legacy payments that may encourage agents and brokers to tell beneficiaries that shopping for a plan each year is unnecessary, and we strongly object to information flowing to agents about beneficiaries' plan choices in subsequent years.

### **3. Administrative Payments**

For consistency with the payment structure outlined above, CMS proposes to remove separate regulatory authority regarding "administrative payments." We support this update, as we agree with CMS's reasoning that the existing framework, and the additional administrative payments it allows, helps MA organizations circumvent the limits on agent and broker compensation.

As part of its argument against separate administrative payments, CMS notes that health risk assessments (HRAs) completed by agents and brokers do not have the same value as those performed and interpreted by health care providers or in a health care setting.<sup>17</sup> We strongly agree and urge CMS to curtail the use of and payment for HRAs conducted by anyone outside of an enrollee's health team.

CMS proposes increasing the standard compensation rate by \$31 to account for some administrative costs, an amount that would be updated annually. We disagree with this proposal, as it would perpetuate financial incentives for agents and brokers to bypass Medigap, even when OM may be a better fit for the beneficiary.

As CMS notes in the proposed rule, "we believe the payments categorized by MA organizations as "administrative expenses," paid by MA organizations to agents and brokers, have significantly outpaced the market rates for similar services provided in non-MA markets, such as Traditional Medicare with Medigap. This is based on information shared by insurance associations and focus groups and published in research articles by groups such as the Commonwealth Fund, which found that "most brokers and agents in the focus groups recalled receiving higher commissions [total payments, including commission and administrative payments]—sometimes much higher—for enrolling people in Medicare Advantage plans compared to Medigap."

CMS also explains the outlined payment changes are intended to "deter anticompetitive practices engaged in by MA organizations, agents, brokers, and TPMOs that prevent beneficiaries from exercising

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<sup>17</sup> 88 Fed. Reg. 78476, 78555.

fully informed choice and limit competition in the Medicare plan marketplace among Traditional Medicare, MA plans, and Medigap plans.”

To meaningfully do so, the agency must not further distort payment rates that impact OM and MA access. According to CMS, the 2023 national agent/broker compensation caps are \$601 for each MA initial enrollment, \$301 for a MA renewal enrollment, \$92 for each Part D initial enrollment, and \$46 for a Part D renewal enrollment. Previous analysis suggests the initial and renewal commissions for Medigap plans are about half of the MA rates (\$322 and \$166 in 2020, respectively).<sup>18</sup>

As these numbers show, MA commissions far outstrip the combined commissions for standalone Part D plans and Medigaps, which means agents and brokers already have strong incentives to favor MA, and selling a single plan, backed by massive marketing infrastructure, skewed benefits, and premium supports through rebates, is likely far easier than selling a combined standalone Part D plan and Medigap.

Instead of further increasing MA-related payments and enrollment incentives, we urge CMS to align commissions more closely between MA and Medigap/Part D. Such payment equity would best encourage agents and brokers to represent plans objectively and prioritize beneficiary needs appropriately.

#### **4. Agent Broker Compensation for Part D Plans**

CMS notes that conforming changes should be made to the sale of standalone Part D plans to prevent those plans from having an unfair advantage—in that they would be able to offer additional payments and perks to FMOs and agents, while MA plan sponsors would be limited by the proposed policies. While we do not object to this change, we think such fears are overblown given the extreme difference in commissions between MA and Part D plans in the current market.

We again urge CMS to explore ways to bring MA and Part D broker compensation into greater alignment to avoid entrenching the current incentives for selling MA plans, which can leave beneficiaries with ill-fitting coverage.

### **VIII. Improvements for Special Needs Plans**

#### **B. Institutional Special Needs Plans (I-SNP) Network Adequacy**

CMS seeks to broaden the acceptable rationales for an exception from the network adequacy requirements for facility-based I-SNPs. While we accept this change in this highly specific circumstance, we urge CMS to move cautiously, and to strengthen general oversight of I-SNPs to ensure people are receiving the care they need.

#### **C. Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization**

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<sup>18</sup> Riaz Ali and Leslie Hellow, “Agent Commissions in Medicare and the Impact on Beneficiary Choice” The Commonwealth Fund (October 12, 2021), <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>.

## **1. Changes to the Special Enrollment Periods for Dually Eligible Individuals and Other Low-Income Subsidy (LIS) Eligible Individuals**

CMS proposes to replace the current quarterly special enrollment period (SEP) for individuals who are dually or LIS eligible with a new continuous SEP, with more limitations. The proposed SEP would allow duals or LIS individuals to elect a new standalone Part D prescription drug plan (PDP) or, for full duals, a Dual Eligible Special Needs Plan (D-SNP), that meets certain integration criteria, in any month.

We support the re-establishment of a monthly enrollment flexibility for low-income beneficiaries. However, we are concerned that this change limits flexibility for non-dual LIS enrollees with MA prescription drug (MA-PD) coverage. Under our understanding of this SEP, if these individuals find their plan does not meet their needs, they would not be able to move to another MA-PD outside of the standard enrollment periods. And because of the lack of comprehensive federal Medigap protections, they may not be able to enroll in a Medigap, limiting their ability to disenroll to OM. While some LIS beneficiaries could still get financial help, such as by qualifying for Medicare Savings Programs (MSPs) that help cover OM costs and through access to enhanced state processes that facilitate these enrollments, others—like those ineligible for the cost-sharing assistance of the Qualified Medicare Beneficiary (QMB) program—would still face unaffordable out-of-pocket costs in Original Medicare. We urge CMS to retain the SEP that allows LIS-eligible beneficiaries to switch from one MA-PD to another quarterly.

Regarding the SEP that would allow dually eligible beneficiaries to elect a sufficiently integrated D-SNP, we do not object to the limitations that CMS proposes to establish to prevent such individuals from enrolling in non-integrated MA plans, but we are concerned that these changes to dual SEP rights may cause significant confusion for beneficiaries and those who assist them. We urge CMS to do more to understand how to convey the value and meaning of integrated options to ensure that potential enrollees do not feel they are being punished or limited by the narrower plan choice available when using the SEP but are in fact getting an added benefit—the ability to enroll in a superior plan. To promote beneficiary choice and understanding, Medicare Plan Finder (MPF) and other CMS tools must make it easy for users to identify which plans are sufficiently integrated, both in general and for those using this SEP. We also urge CMS to pay particular attention to SEP utilization patterns to ensure that plans are not dissuading individuals from staying enrolled, and that there are no other issues that may be causing an individual to switch plans or leave MA.

## **2. Enrollment Limitations for Non-integrated Medicare Advantage Plans**

CMS proposes to limit MA organizations that contract with a state as a Medicaid MCO that enrolls dually eligible individuals in the same service area as D-SNPs offered by the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization, to limit new enrollment to individuals enrolled in (or in the process of enrolling in) the D-SNP's affiliated Medicaid MCO. This would apply when any part of the D-SNP service area overlaps with any part of the Medicaid MCO service area, even if the two service areas do not perfectly align. While we support this goal, we have concerns that this advantages MA plans that do not contract with a state as a Medicaid MCO because they are not subject to any such limitation. It also may negatively affect enrollees if the service areas or provider networks of the Medicare and Medicaid plans are not fully congruent. To this end, we

strongly urge CMS to require full network alignment and transparency before considering a plan to be integrated.

CMS additionally proposes to contract with only one D-SNP for full-benefit dually eligible individuals in the same service area as that MA organization's affiliated Medicaid MCO. We support this effort to reduce confusion and the proliferation of plans but are concerned that these policies would only apply to some D-SNPs, advantaging those that do not fit within the outlined criteria. We recommend a more comprehensive approach. CMS must not grant coordination-only D-SNPs or non-D-SNPs unfettered ability to enter the market while constraining plans with better integration. Doing so would undermine parity and the agency's stated enrollment objectives.

Also under this proposed update, integrated D-SNPs would be required to disenroll individuals who are not enrolled in both the D-SNP and Medicaid MCO offered under the same parent organization (that is, offered by the parent organization or any subsidiary). While we appreciate CMS's goal of ensuring alignment between the D-SNP and the MCO, state realities might make this impossible. In such circumstances and otherwise, the required disenrollment could significantly disrupt care or otherwise cause harm.

Instead of this potentially detrimental approach, we urge CMS to consider a bar on new enrollments without concurrent alignment. In addition, beneficiaries must be given notice and the opportunity to change their mind if their D-SNP enrollment choice—either at initial enrollment, during fall open enrollment, or using an SEP—would trigger a Medicaid plan disenrollment. In our experience, access issues, such as interruptions in care, often arise when enrollment choices trigger other disenrollments. CMS must minimize such outcomes. Exceptions or phase-ins to this rule might be required, for example, in states where Medicaid managed care enrollment is not mandated, where there are no or very few integrated D-SNPs, or where state contracting practices allow for a particular proliferation of MCOs.

CMS acknowledges these proposals may require updates to beneficiary decision-making tools like MPF, and enrollment resources for consumers, SHIP counselors, and others. We agree, and strongly encourage significant updates to MPF so that all beneficiaries receive better information about their options. In particular, those who are dually eligible need to know how D-SNPs function and any benefits a more integrated product may provide them.

We reiterate the need for CMS to comprehensively improve the plan choice architecture and better empower informed decision-making by ensuring all MA plans, and especially all D-SNPs, are high quality, limited in number, and easy to compare. In addition, we urge CMS to improve truly integrated care by requiring all D-SNP providers to accept Medicaid. This would remove a significant hurdle for people who are dually eligible.

#### **D. Comment Solicitation: Medicare Plan Finder and Information on Certain Integrated D-SNPs**

CMS seeks comment on improvements to MPF for certain integrated D-SNPs. We strongly encourage better information for MPF users around the integration level of D-SNPs and clearer explanations for benefits, including which are Medicaid benefits and which are Medicare supplemental benefits. Without this information, MPF users may be misled into believing that the MA plan or D-SNP is providing greater



access to benefits than they truly are, or that a D-SNP interferes with Medicaid benefits or has fewer benefits than other MA plans.

We again urge CMS to do more to highlight D-SNPs when MPF users indicate that they are dually enrolled, including by putting D-SNP results at the top of the page and by giving more information about the integration level—and what such integration means—of each plan.<sup>19</sup> As CMS moves toward higher levels of integration for D-SNPs, its efforts will be less meaningful if individuals do not perceive the advantage and do not seek to enroll in such plans.

Finally, MPF’s lack of plan network and provider information severely curtails its utility. Solving for this requires better underlying data, but accurate provider directories do not exist. CMS must address this without delay and hold beneficiaries harmless in the interim—if the directories are too poor for MPF inclusion, they are too poor for beneficiaries to rely upon at all.

#### **E. Comment Solicitation: State Enrollment Vendors and Enrollment in Integrated D-SNPs**

In our experience, there can be a great deal of confusion and frustration among beneficiaries and advocates who are attempting to enroll or help others enroll in integrated D-SNPs and ensure appropriate verification and information. We agree with CMS that state enrollment vendors may offer a more streamlined approach, as long as there is sufficient oversight to catch any potential steering or lack of objectivity. To that end, we urge CMS to require that such ventures be supplemented by a separate, and independent non-state agency ombudsman program.

We note that these proposals would require extensive Medicare enrollment rules training for the state enrollment vendors to ensure they understand special enrollment periods and other complexities. We have long urged greater Medicare education for anyone working in state Medicaid and other insurance departments to best ensure they are providing appropriate assistance and information to beneficiaries and prospective enrollees.

#### **F. Clarification of Restrictions on New Enrollment into D-SNPs via State Medicaid Agency Contracts (SMACs)**

CMS proposes to make explicit that to be eligible to elect a D-SNP, an individual must also meet any additional eligibility requirements established in the SMAC. We do not object to this proposal.

#### **G. Contracting Standards for Dual Eligible Special Needs Plan Look-Alikes**

##### **1. Reducing Threshold for Contract Limitation on D-SNP Look-Alikes**

CMS proposes to lower the D-SNP look-alike threshold from 80% to 60% incrementally over a two-year period. We strongly support this plan and recommend it be lowered the subsequent year to 50%, with further reductions considered as the plan landscape, and D-SNP integration, continues to shift.

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<sup>19</sup> Association for Community Affiliated Plans, *et al.*, “Letter CMS regarding Medicare Plan Finder” (October 13, 2023), [https://www.scribd.com/document/681343491/Medicare-Plan-Finder-Identified-Changes#from\\_embed](https://www.scribd.com/document/681343491/Medicare-Plan-Finder-Identified-Changes#from_embed).

## **2. Amending Transition Processes and Procedures for D-SNP Look-Alikes**

CMS proposes to limit plan transitions for D-SNP look-alikes to require transitioning dually eligible enrollees into D-SNPs. We strongly support this limitation as the current scheme of allowing transition into non-D-SNPs does not provide any incentive for MA organizations to eliminate D-SNP look-alikes.

### **H. For D-SNP PPOs, Limit Out-of-Network Cost Sharing**

CMS proposes to limit out-of-network cost sharing for D-SNP preferred provider organizations (PPOs) for specific services. The proposed rule would reduce cost shifting to Medicaid, increase payments to safety net providers, expand dually eligible enrollees' access to providers, and protect dually eligible enrollees from unaffordable costs. We support this proposal.

## **IX. Updates to Program of All-Inclusive Care for the Elderly (PACE) Policy**

### **A. Corrective Action**

CMS proposes to specify that, at their discretion, CMS or the state administering agency (SAA) may monitor the effectiveness of corrective actions. We do not support any proposals that reduce the oversight of corrective action plans.

### **B. Service Determination Requests Pending Initial Plan of Care**

CMS proposes to specify that service requests made prior to developing the participant's initial plan of care must either be approved and incorporated into the participant's initial plan of care, or the rationale for why it was not approved and incorporated must be documented. We support this proposal.

## **Conclusion**

Thank you again for the opportunity to provide comment. For additional information, please contact Lindsey Copeland, Director of Federal Policy at [LCopeland@medicarerights.org](mailto:LCopeland@medicarerights.org) or 202-637-0961 and Julie Carter, Counsel for Federal Policy at [JCarter@medicarerights.org](mailto:JCarter@medicarerights.org) or 202-637-0962.

Sincerely,



Fred Riccardi  
President  
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