



266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

VIA ELECTRONIC SUBMISSION

March 7, 2022

Re: [CMS-4192-P] RIN 0938-AU30: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P, P.O. Box 8013,
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs 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 nearly three million people with Medicare, family caregivers, and professionals.

We are particularly pleased by this proposed rule's provisions around Medicare Advantage (MA) dual eligible special needs plans (D-SNPs). The Centers for Medicare & Medicaid Services (CMS) and especially the Medicare-Medicaid Coordination Office (MMCO) have done great work to address the needs of those who are dually eligible for Medicare and Medicaid,

Washington, DC Office:
1444 I Street NW, Suite 1105
Washington, DC 20005
202.637.0961

www.medicarerights.org www.medicareinteractive.org

including the specific needs around integration of care, social determinants of health, and equity. While below we identify places in the proposed rule where we would like more clarity and more protection for beneficiaries, we applaud efforts to ease access to high-quality care that reduces disparities and addresses the needs, the dreams, and the frustrations of older adults and people with disabilities who participate in both programs.

We do note that two important pieces specific to the dually eligible individual population have not been included in these proposals: Medicare provider network adequacy standards to ensure D-SNP enrollees have access to sufficient and appropriate providers and that the providers are congruent with the Medicaid providers in the aligned Medicaid managed care plan; and state ombuds programs. We urge CMS and MMCO to investigate the potential to add these vital pieces in future rulemaking by strengthening network standards and requiring and funding ombuds programs to ensure that dually eligible individuals have access to care and to the assistance they need if things go wrong. In particular, local, community based ombuds programs can bring knowledge of both Medicare and state Medicaid services, creating an invaluable resource for beneficiaries who may be struggling to understand how their benefits work together and who to contact with problems.

In general, throughout this proposed rule and our comments, we note that there is often not enough good data. This includes demographic data, especially on disability and on social, racial and economic status, which leaves current and proposed policies vulnerable to exacerbating gaps in coverage and pernicious inequities. In addition, there are missing data on MA supplemental benefit spending, access, and eligibility. While we support expanding Medicare coverage, where possible, to include wraparound services and supports, we must not simply provide marketing headlines for private industry. Instead, there must be robust oversight and, if necessary, reconsideration of any policies that could lead to higher spending without actually benefiting people with Medicare. Further, we continue to support making all benefits equally available, rather than just to people with MA.

II. Provisions of the Proposed Rule

A. Improving Experiences for Dually Eligible Individuals

3. Enrollee Participation in Plan Governance (§ 422.107)

c. Proposal for D-SNP Enrollee Advisory Committees

CMS proposes to require all MA organizations (MAOs) offering one or more D-SNPs in a state to establish and maintain one or more enrollee advisory committees to solicit direct input on enrollee experiences. We strongly support the requirement to have enrollee advisory committees. Listening to the voices of people with Medicare and Medicaid is the best way to understand their needs, wants, frustrations, and fears.

But we do not support the proposed flexibility in the requirement that would allow one committee to cover more than one D-SNP. We urge CMS to require each D-SNP to have its own committee. By establishing separate committees for each plan, the MAO will not only be better able to include a “reasonably representative sample” of enrollees, but to get meaningful input on access to covered services, service coordination, and health equity for underserved communities. Given the variety in geography and provider density, plan offerings, plan competencies, and underserved communities, a single committee that covers more than one plan will not be able to listen effectively to all enrollees and hear important considerations for their care.

CMS also proposes to be nonprescriptive on meeting frequency, location, format, enrollee recruitment, training, and other parameters. We urge CMS to establish meaningful minimum standards, in consultation with stakeholders, to ensure that the advisory committee meetings are frequent enough to be useful, are accessible to all enrollees—including enrollees with disabilities, limited literacy, and limited English proficiency—and provide accommodations to serve enrollees who lack transportation or access to technology necessary to facilitate robust virtual participation. We also urge CMS to create standards for selecting participants and training processes and to consider whether it is appropriate to compensate enrollees for their participation.

CMS proposes to encourage D-SNPs to solicit input from enrollees on other topics that will be part of the committee’s responsibilities. While this is an important step, we urge CMS to require D-SNPs to provide information to alert enrollees as to the scope of potential topics such as identifying a non-exhaustive list of topics other advisory committees have tackled. Without such information, participants may not be aware of the full scope of the possibilities for feedback.

CMS also states that it would, if this provision is finalized, update the audit protocols for D-SNPs to request documentation of enrollee advisory committee meetings. We support a requirement for D-SNPs to demonstrate compliance with the rules, including showing how the participants are representative of the enrollee population, how often the committee has met, a sampling of feedback from the committee, and outcomes measurement.

We also urge CMS to require D-SNPs to invite State Medicaid agency participation in advisory meetings to increase transparency and the knowledge base of all participants.

4. Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessment

CMS proposes to require SNPs to include one or more standardized questions on the topics of housing stability, food security, and access to transportation as part of their health risk assessments (HRAs). CMS argues that better knowledge of these social factors would better equip the MAOs to develop an effective plan of care and that standardized questions allow for better cross-plan comparisons and data exchange. We support this proposal, but we urge the addition of safeguards to ensure the questions are framed and presented, and the answers are received, in respectful and culturally competent ways. We encourage all such questions to be posed only by people who have had training to combat implicit bias.

While CMS does not explicitly require SNPs to be accountable for resolving all risks identified in these assessment questions, SNPs do need to have some grasp, before any assessment, of the range of possible responses and what resources and other help may be available to fill needs. We urge CMS to provide not just standardized questions but also guidance around framing, an explanation of why the questions are being asked, and expectation setting about how the information will be used to ensure it is maximally actionable, and to avoid enrollees feeling they have exposed their private information for no gain.

We urge CMS to reconsider its decision not to require standardized questions on social isolation—a significant risk factor for loss of cognitive function, cardiovascular illness, and death.¹

As CMS formulates the questions, we ask that they be validated, drawn from best practices, and written at accessible reading levels so they can be effectively used by diverse interviewers with diverse audiences.

5. Refining Definitions for Fully Integrated and Highly Integrated D-SNPs (§§ 422.2 and 422.107)

a. Exclusively Aligned Enrollment for FIDE SNPs

CMS proposes to change the definition of Fully Integrated Dual Eligible (FIDE) and Highly Integrated Dual Eligible (HIDE) SNPs. This change would include requiring that all FIDE SNPs have exclusively aligned enrollment, be capitated for Medicaid services with limited exceptions, operate unified appeals and grievance processes, and continue delivery of benefits during an appeal. This proposal would bar partial-benefit dually eligible enrollees from FIDE SNPs. We strongly support these definitional changes and urge CMS to require plans to make their status as a FIDE or HIDE SNP more transparent to ensure beneficiaries and their advocates can

¹ National Institute on Aging, “Social isolation, loneliness in older people pose health risks” (April 23, 2019), <https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks>.

understand the level of alignment and integration they should expect from their current or potential plan.

b. Capitation for Medicare Cost-Sharing for FIDE SNPs and Solicitation of Comments for Applying to Other D-SNPs

CMS proposes to specify that FIDE SNPs are required to cover Medicare cost sharing for both Qualified Medicare Beneficiary (QMB) and non-QMB full benefit dually eligible enrollees as part of the FIDE SNP's coverage of primary and acute care. This would include all cost-sharing, whether it is in the form of coinsurance, copayments, or deductibles, for Medicare Part A and Part B benefits covered by the D-SNP. We strongly support this proposal because it would allow providers to submit a single claim to the FIDE SNP for both Medicare and Medicaid coverage of the service. This would reduce provider burden and the likelihood that enrollees would find themselves caught in the middle of billing disputes.

CMS also proposes to encourage but not require states to include Medicaid coverage of Medicare Part A and Part B cost-sharing (other than Medicare premiums) for dually eligible individuals in their capitated contracts with all D-SNPs as a method of reducing provider burden and improving access. We support this proposal.

CMS seeks feedback on proposing a requirement for states to provide real-time Medicaid managed care plan enrollment data to D-SNPs to enable better coordination between the D-SNP and the state and/or Medicaid managed care plan. We support real-time data sharing but are aware there may be need for significant investment at the state level to build the infrastructure necessary to support such a system. In our experience, even the current requirement for notification of hospital admission may not be occurring as required. We urge thoughtful consideration of how to support real-time data sharing and how to provide meaningful oversight to ensure the required sharing is actually occurring.

c. Scope of Services Covered by FIDE SNPs

(1) Need for Clarification of Medicaid Services Covered by FIDE SNPs

CMS proposes to revise the definition of a FIDE SNP to clearly specify which services and benefits must be covered under the FIDE SNP capitated contract with the State Medicaid agency. We support this proposal which would bring fuller integration of Medicaid benefits to individuals enrolled in FIDE SNPs.

(2) Requiring FIDE SNPs to Cover All Medicaid Primary and Acute Care Benefits

CMS proposes to revise the definition of FIDE SNP to require qualifying D-SNPs to cover all primary care and acute care services and Medicare cost-sharing – to the extent such benefits are covered for dually eligible individuals in the State Medicaid program – through their capitated contracts with State Medicaid agencies. We support this proposal.

CMS notes that it would not include non-emergency medical transportation (NEMT) as a primary or acute care service included in the scope of this provision. We encourage CMS to reconsider. NEMT services are vital to ensuring dually eligible individuals with transportation gaps can access the care they need. A preliminary study on NEMT access in MA shows that the use of the NEMT MA benefit “is correlated with an average 1.5 times more primary care physician visits than for those beneficiaries who didn’t use the benefit...and those who used the benefit tended to be sicker.”²

CMS seeks comment on whether specific carve outs of some of these benefits and services should be permitted. While we are generally dubious about carve outs because they interfere with true integration, and we understand the value of eliminating such a piecemeal approach, our experience demonstrates that some services may have, historically, not been provided appropriately by managed care plans, leading to provider resistance and significant access problems. In such cases, a state carve out may be necessary to ensure that enrollees have access to the care they need. We urge CMS to work closely with states to determine why certain carve outs exist and what the impact may be on access to care if they were to be eliminated. CMS and states should work together to ensure sufficient oversight where carve outs are eliminated to ensure that plans are meeting all obligations.

(3) Requiring FIDE SNPs to Cover Medicaid Home Health and Durable Medical Equipment

CMS proposes to require that FIDE SNPs cover home health services and durable medical equipment (DME) services to the full extent that those benefits are covered by the State Medicaid program. We support this proposal which will ensure enrollees in FIDE SNPs maintain access to these benefits.

(4) Requiring FIDE SNPs to Cover Medicaid Behavioral Health Services

CMS proposes to require the Medicaid managed care organization (MCO) that is offered by the same entity offering the FIDE SNP to cover all behavioral health services covered by the State

² Medical Transportation Access Coalition, “Considering the Ideal Role for Non-Emergency Transportation in Addressing Social Determinants of Health in Medicaid and Medicare Populations” (February 15, 2022), https://mtacoalition.org/wp-content/uploads/2022/02/Considering-the-Ideal-Role-for-Transportation_2021.12.21_final.pdf.

Medicaid program for the enrollees in the FIDE SNP by including the coverage in the capitated contract with the State Medicaid agency. This would limit the permissible behavioral health carveouts. We support this proposal which will improve the integration of services and signal the importance of behavioral health services and care for whole-body health.

d. Clarification of Coverage of Certain Medicaid Services by HIDE SNPs

CMS proposes to require a HIDE SNP to have a capitated contract with the State Medicaid agency that requires the HIDE SNP to cover, at a minimum, Medicaid long-term services and supports (LTSS) or Medicaid behavioral health services rather than the current ambiguous “coverage, consistent with State policy.” We support this proposal. In our experience, there has been a significant lack of clarity and comprehension around HIDE SNP definitions, and, in general, what can be expected of particular types of SNPs.

e. Medicaid Carve-outs and FIDE SNP and HIDE SNP Status

CMS proposes that a D-SNP may meet the FIDE SNP or HIDE SNP definition even if the contract between the state and the plan carves out some Medicaid LTSS and/or some Medicaid behavioral health services, as long as the carve-outs apply primarily to a minority of beneficiaries eligible to enroll in the D-SNP who use LTSS and/or behavioral health services and supports or constitutes a small part of the total scope of Medicaid LTSS and/or behavioral health services provided to the majority of beneficiaries eligible to enroll in the D-SNP. As we stated above, while we are generally dubious about carve outs because they interfere with true integration, and we understand the value of eliminating the piecemeal approach of carve outs, our experience demonstrates that some services may have, historically, not been provided appropriately by managed care plans, leading to provider resistance and significant access problems. In such cases, a state carve out may be necessary to ensure that enrollees have access to the care they need. We urge CMS to work closely with states to determine why certain carve outs exist and what the impact may be on access to care if the carve outs are eliminated. CMS and states should work together to ensure sufficient oversight where carve outs are eliminated to ensure that plans are meeting all obligations. In the case of LTSS and behavioral health services, at a minimum, we urge guidance for plans to help beneficiaries navigate FFS-Medicaid for any services that have been carved out of their D-SNP and that beneficiaries who may consider enrolling in plans with carve outs are notified that the integrated services do not include Medicaid LTSS and/or behavioral health services to the extent they are carved out.

f. Service Area Overlap between FIDE SNPs and HIDE SNPs and Companion Medicaid Plans

CMS proposes to require FIDE SNP capitated contracts with the State Medicaid agency to cover the entire service area for the D-SNP for plan year 2025 and subsequent years. We support this proposal which will avoid phantom integration of the Medicare and Medicaid plans.

CMS is considering an alternative of establishing a minimum percentage of enrollment or service area overlap between the D-SNP affiliated Medicaid plan and having FIDE SNPs and HIDE SNPs attest to meeting the minimum overlap requirement. We do not support this alternative.

6. Additional Opportunities for Integration through State Medicaid Agency Contracts

a. Limiting Certain MA Contracts to D-SNPs

CMS is proposing to codify a pathway where if a state requires an MA organization to establish a contract that only includes one or more D-SNPs with exclusively aligned enrollment within a state, the MA organization may apply for such a contract using the existing MA application process. We support this proposal and urge CMS to do more to allow for precise understanding of the policies, qualities, and obligations of specific D-SNPs by requiring separate contracts and public posting of model State Medicaid Agency Contracts. This would allow data to more clearly reflect the outcomes, needs, satisfaction, and quality of care for people in D-SNPs. It would also give greater transparency to medical loss ratios (MLRs) for D-SNPs and allow better oversight of the D-SNPs' provider networks.

b. Integrated Member Materials

CMS proposes to codify a pathway by which CMS would coordinate with a state that chooses to require, through its State Medicaid agency contract, that certain D-SNPs use an integrated Summary of Benefits (SB), Formulary, and combined Provider and Pharmacy Directory. CMS also proposes to require that CMS work in good faith with states upon receipt of a letter of intent regarding the state's inclusion of a requirement for a D-SNP with exclusively aligned enrollment to use integrated materials and apply for a D-SNP-only contract. If properly implemented, this would include the work to develop model integrated materials before the State Medicaid Agency contract submissions are due for the contract year for which the D-SNP would use the integrated materials. We strongly support these proposals. We specifically urge the creation of integrated materials in various languages to meet the needs of enrollees and potential enrollees.

CMS is considering including the Evidence of Coverage (EOC) and Annual Notice of Changes (ANOC) as part of the minimum scope of integrated materials. We support this addition.

d. Comment Solicitation on Financing Issues

CMS is assessing whether to use integrated Medicare-Medicaid medical loss ratios. We support requiring the parent organization to provide numbers from both Medicare and Medicaid. This would enable greater transparency about potential cost-shifting between the programs and also the real value of supplemental benefits from MA plans. Similarly, we support close consideration of the expected impact of benefits provided by MA organizations on Medicaid cost and utilization in the evaluation of Medicaid managed care capitation rates for actuarial soundness.

7. Definition of Applicable Integrated Plan Subject to Unified Appeals and Grievances Procedures (§ 422.561)

CMS proposes to expand the definition of applicable integrated plans subject to unified appeals and grievances beyond FIDE SNPs or HIDE SNPs. We support the expansion of this definition. Integration is not truly integration if enrollees still must navigate separate appeals and grievances systems. However, integration cannot stop there. It must result in meaningful communication and coordination between the D-SNP and the Medicaid plan, and inclusion of beneficiary needs, wants, and experiences at every level of plan implementation and in every process. In addition, Medicare plans must understand Medicaid plan benefits and processes and vice versa and always work to facilitate enrollee access to help and information. Beneficiaries must not be put in a position of having to facilitate communication between different parts of “integrated” plans or of having to explain one plan’s or program’s benefits to the other.

We also urge CMS to include information on Medicare Plan Finder that indicates whether a plan has unified grievance and appeals processes. Beneficiaries and enrollment assistors would benefit from easy access to this information, and greater awareness of plans’ obligations may help advocates hold plans properly to account as well as avoid delays and mistakes when assisting with an appeal.

9. Requirements to Unify Appeals and Grievances for Applicable Integrated Plans

a. Providing Enrollees Information on Presenting Evidence and Testimony (§ 422.629(d))

CMS proposes to require plans to provide an enrollee with information on how evidence and testimony should be presented to the plan for an integrated grievance or appeal. We support the codification of this sub-regulatory guidance.

c. Accommodate State Medicaid Representation Rules (§ 422.629(l))

CMS proposes to add language to clarify that an enrollee’s representative includes any person authorized under state law. We support this clarification.

e. Timelines for Processing Payment Requests (§ 422.631)

CMS proposes to require applicable integrated plans to process payment requests according to the prompt payment provisions set forth in § 422.520, which would mirror the current provision at § 422.568(c). We support this proposal. These prompt payment provisions are generally consistent with Medicaid prompt payment standards and therefore would not create any inconsistencies with State Medicaid policies in this area.

f. Clarifying Integrated Reconsideration Request (§ 422.633(e) and (f))

CMS proposes to clarify that an enrollee may request an expedited integrated reconsideration related to payment that can qualify as expedited, but a provider's right to request an expedited integrated reconsideration on behalf of an enrollee is limited to pre-service integrated reconsideration requests. We support this clarification.

g. Timeframes for Service Authorization After a Favorable Decision (§ 422.634(d))

CMS proposes to clarify that an applicable integrated plan must authorize or provide the service as expeditiously as the enrollee's condition requires and within the sooner of: (1) 72 hours from the date of the reversed decision; or (2) 30 calendar days (7 calendar days for a Part B drug) after the date that the applicable integrated plan received the integrated reconsideration request. We support this clarification from the current requirements, which require applicable integrated plans to authorize or provide the service as expeditiously as the enrollee's condition requires but not later than 72 hours from the date of the reversed decision.

12. Attainment of the Maximum Out-of-Pocket (MOOP) Limit (§§ 422.100 and 422.101)

CMS proposes to revise the regulations governing the MOOP limits for MA plans to require that all costs for Medicare Parts A and B services accrued under the plan benefit package, including cost-sharing paid by any applicable secondary or supplemental insurance or any cost sharing that remains unpaid, is counted towards the MOOP limit. We support this proposal. It would reduce the burden on states by limiting state Medicaid liabilities for Medicare costs and may also increase access to providers. In addition, this proposal would standardize MA plan treatment of MOOP calculations by using plan-adjudicated claims data rather than the enrollee's status as a dually eligible individual, thus treating dually eligible and Medicare-only beneficiaries similarly.

13. Comment Solicitation on Coordination of Medicaid and MA Supplemental Benefits

CMS seeks comments on examples of potential coordination of Medicaid and MA supplemental benefits. We are concerned about several aspects of MA supplemental benefits as they

intersect with Medicaid benefits: MA plans may be misleading consumers by advertising Medicaid benefits as MA supplemental benefits; enrollees may have difficulty understanding if or how their needed service is covered and, if so, by whom; where overlap exists, provider and plan confusion may delay or even prevent enrollees from accessing their benefits fully; and there are scant data about how many enrollees gain access to MA supplemental benefits, the value of those benefits, and the resultant outcomes or quality measures associated with that access. We urge very clear communication to enrollees about Medicaid benefits, supplemental benefits, and how the two work together. We also urge rigorous data collection and oversight of supplemental benefits to ensure that they are genuinely used as benefits and not merely marketing gimmicks.

14. Converting MMPs to Integrated D-SNPs,

CMS proposes to work with the states participating in the capitated financial alignment model during CY 2022 to develop a plan for converting MA Medicare-Medicaid Plans (MMPs) to integrated D-SNPs. We urge CMS to work with all stakeholders in these states to identify any state-specific reasons for delaying or avoiding such conversion, and in those states that do not have specific objection, requiring that any MMPs that are converted be converted into FIDE SNPs in order to maintain the fullest level of integration possible.

B. Special Requirements during a Disaster or Emergency (§ 422.100(m))

MA organizations are required to ensure access, and in-network cost sharing, to covered services even when furnished by noncontracted providers “when a disruption of care in the service area impedes enrollees' ability to access contracted providers and/or contracted providers' ability to provide needed services.”³ CMS proposes to limit the special requirements on MA plans during a disaster or emergency to times when there is a disruption in access to health care. Under the proposal, the initial determination of whether there is a disruption of access to health care would rest with MA plans. We are very concerned that this decentralized determination would result in inconsistency, confusion, and reduced access to care. For example, enrollees unable to understand when they may have the right to access services from noncontracted providers may delay care. If this proposal moves forward, we urge extensive oversight of MA decisions and a process for quickly overriding such determinations when they put access to care at risk.

C. Amend MA Network Adequacy Rules by Requiring a Compliant Network at Application

³ 80 Fed. Reg 7953

CMS proposes to require MA organizations (MAOs) applying for a new or expanding service area to demonstrate network adequacy compliance and to deny applications if network adequacy cannot be demonstrated. We strongly support this move to provide greater oversight of MA network adequacy. The current system of having MAOs attest that they meet provider network standards does not protect access to care. Enrollees must be able to access medically necessary services through their MA plan.

CMS also proposes to provide MAO applicants with a temporary 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for all the combinations of county designations. We are wary of this proposal. If it moves forward, we urge CMS to carefully assess how quickly, if at all, the credited plans come into compliance with network adequacy requirements and whether enrollees into these plans are adequately served.

In addition, we reiterate our request that CMS strengthen MA network adequacy generally, including by reversing permission for MAOs to count telehealth-only providers toward network adequacy and by reverting the minimum percentage of enrollees that must reside within the maximum time and distance standards in non-urban counties back to 90 percent. We also continue to urge vigorous oversight of provider directories. These issues combined can leave enrollees scrambling to find care within their allowed networks.

E. Past Performance (§§ 422.502, 422.504, 423.503, and 423.505)

CMS proposes to expand the bases for MAO application denials to include Star Ratings history, bankruptcy proceedings, and certain CMS compliance actions. CMS also proposes to codify the types of compliance notices which will be used as a factor in CMS' review of an organization's past performance. We support these proposals. Organizations that are demonstrably poor performers put beneficiaries at risk for inadequate health care services and prescription drug access.

F. Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees

1. Required Materials and Content

CMS proposes to rectify an oversight in the January 2021 final rule—which codified much of the communications and marketing guidance previously found in the Medicare Communications and Marketing Guidelines (MCMG)—by codifying additional MCMG guidance that was inadvertently excluded.⁴ Specifically, the agency seeks to require Part D sponsors with limited

⁴ 86 Fed. Reg. 5864

access to preferred cost sharing pharmacies to provide a disclaimer alerting beneficiaries that the preferred costs may not be available at the pharmacy they use, and giving them information about how to access the list of pharmacies offering prescription drugs at a preferred cost in the beneficiary's area. We support this proposal.

3. Multi-language Insert

CMS proposes to reinstitute a requirement to use a multi-language insert in all required materials that states “We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service.” in the 15 most common non-English languages in the United States. Medicare Rights vociferously objected to the rule that weakened notice requirements around language access and interpreter services and we strongly support this reversal.⁵

4. Third-Party Marketing Organizations (TPMOs)

On Medicare Rights Center's national helpline, we have seen nearly a doubling of cases around inappropriate marketing in recent years. In addition, we are seeing increases in callers who want to change their coverage outside of their enrollment periods because of television ads. Because of this, we are pleased to see CMS take some steps to hold plans accountable for third-party marketing. While these steps are important to rein in some of the worst abuses in TPMO advertising, we are concerned that they will not do enough to protect people with Medicare from aggressive and predatory marketing.

CMS notes that plans must not engage in activities that could mislead or confuse Medicare beneficiaries and that MA organizations and Part D sponsors are ultimately responsible for ensuring that the marketing and enrollment activities done by them or on their behalf is not misleading or confusing. We agree, but we have long been concerned that plans are not held accountable for these rules, and that this lack of vigorous enforcement has emboldened plans in ignoring marketing requirements.

In addition, we are concerned that a dearth of data around supplemental benefits has enabled MA plans to use the availability of such benefits as a marketing tool rather than as a true benefit, in violation of program rules. Without solid information about who has access to such

⁵ Medicare Rights Center, “Comments: Re: Nondiscrimination in Health and Health Education Programs or Activities [RIN 0945-AA11]” (August 13, 2019), <https://www.medicarerights.org/policy-documents/comments-nondiscrimination-in-health-and-health-education-programs-or-activities>.

benefits and to what extent, what they cost, and whether they are administered fairly and without inappropriate discrimination, we cannot be sure they are more than window dressing.

CMS proposes to require TPMOs marketing MA or Part D plans to use a standardized disclaimer that states “We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options.” CMS would require MA organizations and Part D sponsors to ensure that any TPMO with which they do business, either directly or indirectly, utilizes this disclaimer where appropriate. We support this requirement. We are, however, concerned that disclaimers and similar notices may not prove effective at making beneficiaries aware of the risks of enrolling in plans via third parties that are deliberately limiting the information they share for their own purposes.

In addition, CMS proposes making plans responsible for ensuring the TPMO adheres to any requirements that apply to the plan, and would prohibit plans from purchasing the services of a TPMO, which could otherwise allow them to evade compliance responsibilities.

CMS notes that it is the responsibility of the MA organization or Part D sponsor to have knowledge of how and from where leads or enrollments are obtained and proposes to require plans and their first tier, downstream or related entities (FDRs) to require TPMOs to disclose to the plan any subcontracted relationships used for marketing, lead generation, and enrollment; require sales calls with beneficiaries to be recorded in their entirety; and have TPMOs report to plans any staff disciplinary actions associated with Medicare beneficiary interaction on a monthly basis. CMS also proposes to require that plans ensure that TPMOs conducting lead generating activities must inform the beneficiary that his or her information will be provided to a licensed agent for future contact, or that the beneficiary is being transferred to a licensed agent who can enroll him or her into a new plan. We strongly agree with these proposals. As above, we do have concerns that there is insufficient oversight and penalty to hold plans accountable for their behaviors, let alone the behaviors of their FDRs and TPMOs.

We continue to be concerned by the lack of specific rules around marketing of supplemental benefits and urge clarification. We also urge CMS to consider ways to link this new supplemental benefit data to Medicare Plan Finder and other tools that beneficiaries and their advocates use to choose plans. Currently, beneficiaries are unable to assess the true availability or value of such benefits prior to making an enrollment choice.

Finally, we also urge CMS to roll back changes to marketing guidelines that weakened consumer protections, including blurring the distinction between marketing and educational events.⁶

G. Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data

2. Proposal to Reinstate Detailed MLR Reporting Requirements (§§ 422.2460 and 423.2460)

CMS proposes to reinstate the detailed MLR reporting requirements that were in effect for CYs 2014 through 2017. We strongly support this proposal which would aid non-audit oversight and ensure beneficiaries are enrolled in plans that meet regulatory requirements.

3. Proposed Changes to Medicare MLR Reporting Regulations, Data Collection Instrument, and Regulations Authorizing Release of Part C MLR Data (§§ 422.2460, 422.2490, and 423.2460)

CMS proposes to require MAOs to separate out benefits covered by Medicare Parts A and B, certain additional supplemental benefits, and Part D prescription drug benefits. We strongly support this separate accounting. Currently, the amount MA plans spend on supplementary benefits is shrouded in mystery, and this lack of information denies beneficiaries the ability to meaningfully compare plans. We have had grave concerns, especially since the introduction of expanded supplemental benefits, that MAOs are able to use the existence of such benefits as a marketing talking point without having to demonstrate that they actually provide the benefits, and that they do so in a non-discriminatory way that provides value to enrollees and Medicare.

As stated above, we continue to be concerned by the lack of specific rules around marketing of supplemental benefits and urge clarification. We also urge CMS to consider ways to link this new supplemental benefit data to Medicare Plan Finder and other tools that beneficiaries and their advocates use to choose plans.

H. Pharmacy Price Concessions in the Negotiated Price (§ 423.100)

3. Proposed Changes to the Definition of Negotiated Price (§ 423.100)

CMS proposes to redefine “negotiated prices” to mean the lowest amount a pharmacy could receive as reimbursement for a covered Part D drug under its contract with the Part D sponsor or the sponsor’s intermediary. This would include all pharmacy price concessions and any dispensing fees, and exclude additional contingent amounts (such as incentive fees) if these amounts increased prices. We strongly support this change which would increase transparency,

⁶ Medicare Rights Center, “Comments: Re: 2019 Final Medicare Communications and Marketing Guidelines (MCMG)” (August 10, 2018), <https://www.medicarerights.org/policy-documents/comments-re-2019-final-medicare-communications-and-marketing-guidelines-mcmg>.

reduce incentives to drive up negotiated prices, and make beneficiary charges more reflective of true drug costs. We urge CMS to apply these rules throughout the year, including in the coverage gap, to better ensure beneficiaries have predictable and comprehensible pharmacy costs.

While transparency is important, it is of course not the only needed solution. We urge CMS to further improve the system and beneficiary access by streamlining Part D appeals. For example, CMS should explicitly require Part D plans to treat refusals at the pharmacy counter or other point-of-sale as the initial coverage determination, at which time the beneficiary has the option to automatically initiate the appeals process. We also support requiring the addition of individually tailored language to the existing standardized notice at the pharmacy. Beyond the plan contact information, including phone and online access, and clear guidance on the next steps in the appeals process, the denial notice should include a clear explanation of the reason the drug is refused.

Thank you again for this opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,



Fred Riccardi
President
Medicare Rights Center