Center for Medicare Advocacy

Advancing Access to Medicare and Health Care

January 5, 2024

Submitted Electronically via www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: 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)

Dear Administrator Brooks-LaSure:

The Center for Medicare Advocacy (the Center) is a national, non-profit law organization that works to ensure access to Medicare, health equity, and quality healthcare. The organization provides education, legal assistance, research and analysis on behalf of older people and people with disabilities, particularly those with long-term conditions. The Center's policy positions are based on its experience assisting thousands of individuals and their families with Medicare coverage and appeal issues. Additionally, the Center provides individual legal representation and, when necessary, challenges patterns and practices that inappropriately deny access to Medicare and necessary care. We appreciate the opportunity to submit these comments to the above referenced proposed rule.

These comments are also submitted on behalf of California Health Advocates (CHA). Founded in 1997, California Health Advocates is the leading Medicare advocacy and education non-profit in California. CHA is dedicated to providing quality Medicare, Medicare Supplement, and long-term care insurance information, training, and education. CHA supports the local Health Insurance Counseling and Advocacy Programs (HICAP) with training, materials and technical assistance. HICAP is California's State Health Insurance Assistance Program (SHIP).

Overview

The Center applauds CMS for its efforts to strengthen consumer protections for Medicare beneficiaries and increase oversight of Medicare Advantage (MA) and Part D plans. The final 2024 Part C & D rule made many important changes, including those concerning MA prior authorization and marketing, that are starting to make a difference for beneficiaries. This proposed 2025 rule further demonstrates CMS' commitment to protect people with Medicare, and the Center supports most of the proposals in the rule. There is, however, more to do, and we will continue to point out where CMS can make further headway in properly overseeing private MA and Part D plans and those who sell them.

Comments to Provisions of the Proposed Rule

II. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies; Past Performance (p. 78483)

We generally support CMS' efforts to clarify the basis for application denials due to past performance, including records of sanctions and other non-compliance and "to ensure that the factors adequately account for financial difficulties that should prevent an organization from receiving a new or expanded MA or Part D contract" (p. 78482). CMS states that its "proposal reflects our stated intent to deny applications from MA organizations and Part D sponsors when an active sanction existed during the relevant 12-month review period when we previously codified that intermediate sanctions are a basis for denial of an application from an MA organization or Part D sponsor" articulated in the January 2021 final rule.

We urge CMS to further strengthen oversight of MA plans including using its discretion to expand the scope of corrective action plans, including civil monetary penalties, in order to hold plans accountable for inappropriate behavior. With more than half of the Medicare population now enrolled in MA plans, it is unclear if CMS' resources and staff have been allocated accordingly in order to provide necessary regulatory oversight and enforcement. Congress should invest additional funding in the agency's oversight, and provide CMS with additional tools to hold plans accountable, including enhanced enforcement measures such as higher civil monetary penalties and more meaningful sanctions, and the ability to terminate plan contracts due to misconduct. Further, CMS should work more closely with state departments of insurance and the National Association of Insurance Commissioners (NAIC) to ensure that agents, brokers, and plan sponsors are held accountable for misconduct.

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

Expanding Network Adequacy Requirements for Behavioral Health (p. 78483)

The Center appreciates the intent behind CMS's proposed rule to add Outpatient Behavioral Health to the list of provider specialties at § 422.116(b) for which Medicare Advantage (MA) plans must ensure adequate networks, and the corresponding time and distance standards at § 422.116(d)(2). We commend CMS for recognizing the importance of the newly covered mental health counselors (MHCs) and marriage and family therapists (MFTs) under Medicare, as well as opioid treatment programs (OTPs) to meet the needs of beneficiaries with SUDs, and we strongly support examining network adequacy for these providers. However, **we recommend CMS require tracking of this facility type by separately reporting metrics for "Outpatient Mental Health" and "Outpatient Substance Use Disorder" providers (rather than a combined category) and also shorten the maximum time and distance standards to align with those for qualified health plans.**

A. Separate Categories for Outpatient Mental Health and Outpatient Substance Use Disorder

Collapsing MH and SUD facilities into one category will not track the availability of the respective services and will likely mask the limitations in SUD provider availability that exceed MH. In practice, having access to one of these types of providers would currently not translate to greater access for a beneficiary who has a diagnosis in the other category. Under federal law, community-based SUD treatment facilities are not covered by Medicare, even though Community Mental Health Centers are, and OTPs are only permitted to treat Medicare beneficiaries with an opioid use disorder (OUD). 42 U.S.C. 1395x(jjj)(1). Additionally, in many states, MH providers are actually prohibited from treating patients with SUD diagnoses. CMS has previously noted these limitations in its recently finalized Physician Fee Schedule (PFS) and Outpatient Prospective Payment System (OPPS) rules by authorizing coverage of addiction counselors under the definition of MHCs as well as OTPs as an approved setting for intensive outpatient treatment.

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. While some Community Mental Health Centers do provide SUD treatment, they often do so only for people with co-occurring MH diagnoses, and there are no requirements in the conditions of participation that these facilities have staff to treat patients with SUD or the levels of care or medications necessary for such treatment. CMS has also proposed to include physician assistants, nurse practitioners, and clinical nurse specialists "who regularly furnish or will furnish behavioral health counseling or therapy services" in this category, without any requirement that these practitioners actually be providing or submitting claims for MH and SUD services. The proposed category is currently too broad to achieve CMS's stated – and critically important – purpose of improving access to outpatient MH and SUD treatment for Medicare beneficiaries in MA plans.

We continue to urge CMS to develop a separate network adequacy facility category for OTPs. OTPs play a pivotal role in curbing the addiction and overdose epidemic in the U.S., especially for Black and brown individuals who have greater access to these facilities but often lack sufficient access to office-based SUD treatment.[1] CMS notes that Medicare fee-for-service (FFS) claims data for 2020 show that OTP providers had the largest number of claims for SUD services during that timeframe, and the number of Medicare beneficiaries that have been able to receive treatment from OTPs continued to rise in 2021.[2] Beneficiaries who receive methadone for opioid use disorder at OTPs must travel to the OTP nearly, every day for several years to receive their medication, which is why MA plans must maintain adequate access to OTPs, as measured separately from other facility types. We have heard from OTP providers across the country who have struggled to gain credentialing with MA plan networks and others that have even exited the Medicare program altogether because of their negative experiences with some MA plans – specifically low reimbursement rates, lengthy periods for contracting and network admission,

[1] William C. Goedel et al., "Association of Racial/Ethnic Segregation with Treatment Capacity for Opioid Use Disorder in Counties in the United States," JAMA Network Open (Apr. 22, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764663.

[2] U.S. Dep't. Health & Human Services, Office of Inspector General, "Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue to be Concerns for Medicare Beneficiaries" (Sept. 2022), https://oig.hhs.gov/oei/reports/OEI-02-22-00390.pdf.

and reimbursement delays. By requiring MA plans to separately track and maintain adequate networks of OTPs, CMS can help mitigate these barriers to medications for opioid use disorders (MOUD) for MA enrollees.

Ideally, we recommend CMS create one category for OTPs and another category for Outpatient SUD that would capture the other practitioners who deliver these services. Absent creating a separate network adequacy facility type for OTPs, we urge CMS to create a category for Outpatient SUD that would encompass both OTPs and outpatient SUD practitioners, especially to the extent that it could help increase access to buprenorphine for Black and brown beneficiaries and improve health equity, consistent with other provisions in this proposed rule. By establishing a separate Outpatient SUD category, CMS will help to ensure beneficiaries can receive treatment in the settings in which they are most comfortable receiving care, be that OTPs or office-based settings, without over-inflating these networks by including MH providers who are unable to treat beneficiaries with SUDs. We believe that establishing separate network adequacy standards for Outpatient SUD from Outpatient MH will both incentivize MA plans to offer more favorable network contracts to SUD providers and increase access to MOUD for all Medicare beneficiaries, as recommended by the OIG for several years.[3] It will also ensure that Medicare beneficiaries with alcohol use disorder – the most common SUD among Medicare beneficiaries[4] – and other SUDs will not be left behind by this initiative.

Finally, we recommend that CMS not include practitioners that are not specifically licensed or certified to furnish MH or SUD services in this new facility category unless there are clear guardrails that demonstrate that such practitioners are regularly delivering MH and SUD services and meeting Medicare beneficiaries' needs. As proposed, MA plans could include physician assistants, nurse practitioners, and clinical nurse specialists (an important group of practitioners who prescribe buprenorphine), but without a requirement that they actually deliver these services. Plans may also include practitioners who screen patients for MH and SUDs but do not have the skill, training, or expertise to treat those conditions and must then refer patients to specialists for the actual treatment of these conditions, which defeats the entire purpose of this proposed rule. Inclusion of these non-specialized practitioners in the network adequacy metrics would merely perpetuate the problems with ghost networks that are so rampant in MA plans,[5] and fail to meaningfully expand access to outpatient MH and SUD treatment in line with CMS's intent.

We recommend that CMS limit the inclusion of practitioners in this category (or as previously discussed, two distinct categories for outpatient MH and outpatient SUD) to those who are licensed, certified, or accredited to treat MH and SUD, or otherwise within the scope of their practice, consistent with the network adequacy standards CMS adopted for qualified health plans

[3] *Id*.
[4] William J. Parish et al., "Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers," Am. J. Prev. Med. (Mar. 21, 2022), https://pubmed.ncbi.nlm.nih.gov/35331570/.
[5] Senate Finance Committee, "Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.

last year.[6] At the same time, CMS should require the MA plan to demonstrate that a provider has submitted a sufficient number of MH or SUD claims (for the respective category) within the past year, and thus regularly provide MH and/or SUD treatment consistent with CMS's intent. To further address the problem of ghost networks, we also recommend that CMS consider applying this requirement – MA plans only counting providers that have submitted a sufficient number of claims within the past year to reflect active engagement in the network – to all network adequacy standards.

B. Align Network Adequacy Standards with Those for Qualified Health Plans

We strongly recommend shortening the time and distance standards, consistent with the qualified health plan (QHP) standards. MH and SUDs are chronic conditions that require ongoing treatment, including individuals deemed to be in "recovery." Even when these conditions are stabilized, many people remain in counseling on a weekly basis, and individuals who are receiving medications must have recurring evaluation and management visits. People who receive methadone from OTPs are visiting their providers even more frequently.

As previously noted, last year, CMS finalized maximum time and distance standards for QHPs,[7] including an individual provider specialty type for "Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)," which are approximately half those that are proposed by CMS for MA beneficiaries (see tables below). We urge CMS to establish consistent standards across financing systems, which will both help patients and the plans that operate in these spaces. We believe these shorter time and distance standards used for QHPs are more appropriate to meet the needs of individuals with SUDs and MH conditions both because of the frequency at which MA enrollees must visit these providers and because Medicare beneficiaries are older and/or have disabilities, and therefore are more likely to experience greater transportation barriers. Although MH and SUD practitioners are collapsed into one category for QHPs, we, nonetheless, believe it is necessary to separate them for MA plans, as the former is subject to the Mental Health Parity and Addiction Equity Act, which requires a separate analysis of network adequacy for MH and SUD, while MA plans are still under no obligation to do so as they are not subject to the Parity Act.

We appreciate and support this proposal to improve network adequacy enhancements regarding providers of behavioral health services. As the Center has asserted before, however, CMS must, among other things, reinstate the requirements as they were prior to being weakened by provisions of CMS' final 2021 Part C & D rule. In addition, in order to improve access to acute and post-acute care for MA enrollees, we urge CMS to include inpatient rehabilitation facilities (IRFs), comprehensive outpatient rehabilitation facilities (CORFs), and long-term acute care hospitals (LTCHs) in the list of facility-specialty types that are subject to MA network adequacy evaluations per 42 CFR §422.116(b)(2).

[6] Centers for Medicare & Medicaid Services, "2023 Final Letter to Issuers in the Federally-facilitated Exchanges" 13 (Apr. 28, 2022), https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf.
[7] *Id.*

Codification of Complaints Resolution Timelines and Other Requirements Related to the Complaints Tracking Module (CTM) (p. 78512)

CMS proposes to codify existing guidance for the timeliness of complaint resolution by plans in the CTM. CMS proposes to "codify the expectation in guidance that Cost plans and PACE organizations also address and resolve complaints in the CTM. We are proposing to codify the existing priority levels for complaints based on how quickly a beneficiary needs to access care or services and to codify a new requirement for plans to make first contact with individuals filing nonimmediate need complaints within three (3) calendar days. This time frame would not apply to immediate need complaints because those complaints need to be resolved within two calendar days" (p. 78512).

We generally support these proposals. We also concur with and support CMS' statement (at 78513) that:

> Although those regulations permit an extension of up to 14 days for resolving the grievance if the enrollee requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee, we do not believe that including the authority to extend the deadline to resolve complaints in the CTM is appropriate because complaints received into the CTM are often the result of failed attempts to resolve issues directly with the plan. Allowing plans to further extend the time to resolve the complaint only allows further delays in addressing beneficiary concerns.

Although beyond the scope of what is raised in the proposed rule, the Center urges CMS to further review the CTM process and make additional changes. In our interaction with SHIP programs across the country, we regularly hear complaints about resolution of complaints through the CTM process, which appears to have become more challenging over the last several years. Based on the feedback we have received, we suggest that CMS:

- Require CTM decision-makers – whether CMS or plan staff – to cite the specific Medicare law, regulation, rule or other guidance relied upon in order to make the decision in question. For example, some SHIPs report that CMS' focus appears to be on whether or not person "has access to care" or "coverage" or "no continuity of care issues" or "no adverse effects" from the enrollment when, e.g., the initial complaint relates to inappropriate marketing by a broker/agent resulting in an individual being enrolled in a plan they did not seek. In another example, one SHIP was told that an individual can only use one Special Enrollment Period (SEP) among the many types of SEPs per year, however no such restriction exists under Medicare rules.
- Require initial responses to a CTM complaint to include a CTM number and plan (or CMS) contact information (e.g. assigned person with phone/email). CMS should also allow a beneficiary to officially designate another contact for plan and/or CMS to follow up with (e.g. a SHIP counselor).
- Tighten rules surrounding when a plan can close a complaint. We have received reports that plans often prematurely close complaints because they call beneficiaries outside of

work hours and then claim they "can't reach" an individual. SHIPs note that some complaints must be reopened multiple times for the issue to be resolved.
- Increase transparency and access for SHIP programs using CTM. SHIPs can't currently see CTMs entered by 1-800-MEDICARE, rather they can only access complaints initiated by the given SHIP.
- Require timely entry of notes into the CTM. SHIPs complain that often notes are not entered in a timely manner by plan representatives, which can compromise effective problem resolution for their clients. Need for timely notes entered into CTM.

Parallel Marketing and Enrollment Sanctions Following a Contract Termination (p. 78522)

CMS proposes that "effective contract year 2025, marketing and enrollment sanctions will automatically take effect after a termination is imposed" (p. 78522). CMS notes that the intent of this proposal is to prevent an MA or Part D plan sponsor from marketing and enrolling beneficiaries into plans under a terminating contract. We strongly support this proposal.

Update to the Multi-Language Insert Regulation (p. 78523)

CMS is proposing to better align these requirements for MA and Part D plans with existing Medicaid requirements and the proposed requirements for Notice of Availability of both language access services and auxiliary aids and services under Section 1557 of the ACA. Accordingly, CMS is proposing to require integrated plans to offer a Notice of Availability in the top 15 languages of the state.

The Center strongly supports the proposal to amend §§ 422.2267(e)(31) and 423.2267(e)(33) to require MA and Part D plans to provide a Notice of Availability in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency of the relevant State. We support the continued requirement for plans to include notices in additional languages that meet the 5% threshold in the plan service area. We also strongly support that the Notice of Availability must be provided in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication. Requiring notice of availability of alternate formats would align with the proposed Notice of Availability requirements under Section 1557 non-discrimination rules; we support this change.

IV. Benefits for Medicare Advantage and Medicare Prescription Drug Benefit Programs (p. 78534)

Evidence as to Whether a Special Supplemental Benefits for the Chronically Ill (SSBCI) Has a Reasonable Expectation of Improving the Health or Overall Function of an Enrollee (p. 78534)

While we firmly believe that supplemental benefits should be available in traditional Medicare (and therefore available to everyone, instead of just those who choose to enroll in an MA plan (or were enrolled through a former employer)), we generally support CMS' proposed "regulatory changes that would help ensure that SSBCI items and services offered are appropriate and improve or maintain the health or overall function of chronically ill enrollees" (p. 78477).

We support CMS' proposal to require that an MA organization must be able to demonstrate through relevant acceptable evidence that an item or service offered as SSBCI has a reasonable expectation of improving or maintain the health or overall function of a chronically ill enrollee, and must establish a bibliography of this evidence (p. 78477). We also support clarifying that an MA plan must follow its written policies based on objective criteria for determining an enrollee's eligibility for an SSBCI when making such eligibility determinations. Additionally, we support the proposal to codify CMS' authority to review and deny approval of an MA organization's bid if the MA organization has not demonstrated, through relevant acceptable evidence, that its proposed SSBCI has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. We also support codification of CMS' authority to review SSBCI offerings annually for compliance.

We also support the proposal to require MA plans to document denials of SSBCI eligibility. But see no reason to alleviate plans of the obligation to also document approvals.

Mid-Year Enrollee Notice of Unused Supplemental Benefits (p. 78539)

Given that MA plans report increased offerings of supplemental benefits but low utilization of such benefits, CMS proposes to require MA plans to notify enrollees mid-year of the unused supplemental benefits available to them. The notice would list any supplemental benefits not utilized by the beneficiary during the first 6 months of the year. We agree with CMS' assertion that "[t]his policy aims to educate enrollees on their access to supplemental benefits to encourage greater utilization of these benefits and ensure MA plans are better stewards of the rebate dollars directed towards these benefits" (p. 78477). We support this proposal.

Annual Health Equity Analysis of Utilization Management Policies and Procedures (p. 78540)

In the 2024 final Part C & D rule, CMS instituted significant changes to the way that MA plans can employ prior authorization, with the intent to reduce inappropriate denials and delays in care. The Center continues to applaud CMS for taking these critical steps, and as these changes become effective on January 1, 2024, we will be watching closely to monitor plan compliance.

In this rule, CMS is proposing regulatory changes to the composition and responsibilities of MA plans' Utilization Management (UM) committees. Specifically, CMS is proposing to: require that a member of the UM committee have expertise in health equity; that the UM committee conduct an annual health equity analysis of the use of prior authorization, which "would examine the impact of prior authorization on enrollees with one or more of the following social risk factors (SRFs): (i) receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid (LIS/DE); or (ii) having a disability" which "must compare metrics related to the use of prior authorization for enrollees with the specified SRFs to enrollees without the specified SRFs"; and require MA organizations to make the results of the analysis publicly available on their website in a manner that is easily accessible and without barriers" (pp. 78477-8).

On one hand, we appreciate that this proposal would increase oversight of MA plans and allow for more public access to plan performance. We also welcome the agency's ongoing attention to health equity. On the other hand, we believe that there is more unfinished work to be done in order to meaningfully rein in inappropriate MA denials and delays in care. While we recognize

that this rule will be finalized just as the agency is beginning to assess the impact of the prior authorization changes effective in 2024, we urge CMS to provide more guidance – either through sub-regulatory guidance or through further rulemaking – in order to clarify the current new rules relating to prior authorization. The Center outlined many of our suggestions for further improving MA prior authorization requirements in our comments to the 2024 proposed Part C & D rule.[8] In addition, as discussed in one of our recent *CMA Alerts* (Dec. 7, 2023),[9] many provider groups are expressing concerns that MA plans do not intend to follow these new rules. In addition to hospital associations expressing such concerns, the Center recently joined several provider organizations, including LeadingAge, American Health Care Association (AHCA), National Association for Home Care & Hospice (NAHC), American Medical Rehabilitation Providers Association (AMPRA) and The National Association of Long-Term Care Hospitals (NALTH) in sending a letter (dated November 29, 2023)[10] to CMS requesting additional sub-regulatory guidance to clarify provisions of the final 2024 Part C &D rule that outlines new requirements for MA plans and their use of prior authorization. In short, the Center supports this proposal, but urges CMS to do much more in order to effectuate their intent to adequately protect MA enrollees.

V. Enrollment and Appeals (p. 78542)

Revise Initial Coverage Election Period Timeframe To Coordinate With A/B Enrollment (p. 78542)

CMS proposes to revise the MA Initial Coverage Election Period (ICEP), the period during which an individual newly eligible for MA may make an initial enrollment request into an MA plan, by changing the end date of the ICEP to 2 months after the month in which they are first entitled to Part A and enrolled in Part B. We support this proposal.

While we recognize that Congress must act in order to make significant changes to enrollment periods, we urge CMS to press policymakers to equalize enrollment opportunities between MA, Part D and Medigap plans. Specifically, beneficiaries in traditional Medicare should have an opportunity to change stand-alone Part D plans (PDPs) during the first 3 months of the year – an option that is available to people who wish to change MA plans through the Medicare Advantage Open Enrollment Period (MA-OEP). Similarly, federal Medigap rights should be expanded to allow individuals to purchase such plans on at least an annual basis.[11]

Enhance Enrollees' Right To Appeal an MA Plan's Decision To Terminate Coverage for Non-Hospital Provider Services (§ 422.626) (p. 78544)

CMS proposes to: (1) require the QIO, instead of the MA plan, to review untimely fast-track appeals of an MA plan's decision to terminate services in an HHA, CORF, or SNF; and (2) fully

[8] https://medicareadvocacy.org/wp-content/uploads/2023/02/C-and-D-Comments-CY-2024.pdf
[9] https://medicareadvocacy.org/insurance-industry-group-issues-misleading-medicare-advantage-report/
[10] https://leadingage.org/wp-content/uploads/2023/11/PAC-Association-CMS-Letter-re-MA-Subreg-Guidance-FINAL-112923.pdf
[11] For more information about expanding Medigap rights and protections, see the following Stetson University Journal of Law and Policy article by CMA attorney Kata Kertesz: *Expansions of Medigap Consumer Protections are Necessary to Promote Health Equity in the Medicare Program* (Spring 2022).

eliminate provision requiring the forfeiture of an enrollee's right to appeal a termination of services decision when they leave the facility. CMS notes: "Presently, if an MA enrollee misses the deadline to appeal as stated on the NOMNC, the appeal is considered untimely, and the enrollee loses their right to a fast-track appeal to the QIO. Enrollees may, instead, request an expedited reconsideration by their MA plan, as described in § 422.584. The QIO is unable to accept untimely requests from MA enrollees but does perform appeals for untimely requests from Medicare beneficiaries in Original Medicare as described at § 405.1202(b)(4)" (p. 78544).

As noted by CMS "[t]hese proposals would bring MA regulations in line with the parallel reviews available to beneficiaries in Traditional Medicare and expand the rights of MA beneficiaries to access the fast-track appeals process" (p. 78478).

We strongly support this proposal to align MA regulations regarding fast-track appeals with traditional Medicare rules.

Amendments to Part C and Part D Reporting Requirements (p. 78544)

CMS proposes to "lay the groundwork for new data collection to be established through the Paperwork Reduction Act (PRA) process, which would provide advance notice to interested parties and be subject to public comment. An example of increased data collection could be service level data for all initial coverage decisions and plan level appeals, such as decision rationales for items, services, or diagnosis codes to have better line of sight on utilization management and prior authorization practices, among many other issues" (p. 78478).

We support CMS' efforts to collect and publicly report more information about how people access their MA benefits, including denials and delays in care. We urge CMS to act expeditiously to collect such information. KFF issued a report[12] in 2023 that highlights data gaps – both in information that CMS collects but does not report, as well as information that is not required to be reported by MA plans. This report should be used as a roadmap for additional, required reporting requirements by plans relating to information that should be publicly available, including:

- What share of Medicare Advantage enrollees use supplemental benefits offered by their plan and how does use vary by race/ethnicity, income, or health condition?
- What services and subgroups of enrollees, such as those with specific health conditions, have the highest prior authorization denial rates?
- Reason for prior authorization denials - Do certain insurers attribute denials of prior authorization requests to medical necessity more often than others?
- Do certain insurers respond to prior authorization requests more quickly?
- How often do Medicare Advantage insurers deny payments for Medicare-covered services?

[12] https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/

Amendments To Establish Consistency in Part C and Part D Timeframes for Filing an Appeal Based on Receipt of the Written Decision (§§ 422.582, 422.584, 422.633, 423.582, 423.584, and 423.600) (p. 78545)

CMS proposes to extend the current 60-day timeframe to file an appeal with an MA or Part D plan to include 5 additional days as proof of receipt of the written determination notice. The additional time period would also apply to expedited appeal requests, expedited organization determinations and coverage determinations. This is an issue that the Center has raised with CMS in the past, and we applaud CMS for addressing it here. We strongly support this proposal.

VI. Medicare Advantage/Part C and Part D Prescription Drug Plan Marketing and Communications (p. 78549)

Marketing and Communications Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.2267) (p. 78549)

The Center appreciates the review that CMS has conducted regarding the disclaimers in marketing and communications for Special Supplemental Benefits for the Chronically Ill (SSBCI). We support the proposal to expand the current required SSBCI disclaimer to include more specific requirements, with the intention of increasing transparency for beneficiaries and decreasing misleading advertising by MA organizations. We agree that the proposed expansion of the SSBCI disclaimer would clarify what must occur for an enrollee to be eligible for the SSBCI. We agree with CMS' observation that "[i]n many instances, MA organizations have been found to use marketing to potentially misrepresent the benefit offered, oftentimes not presenting a clear picture of the benefit and limits on eligibility." CMS "propose[s] to expand the current required SSBCI disclaimer to include more specific requirements, with the intention of increasing transparency for beneficiaries and decreasing misleading advertising by MA organizations" (78550). The Center has long called for additional clarity re: SSBCI for beneficiaries.[13] We support these proposals, including the proposed amendment to the disclaimer.

We agree that this is likely to reduce the potential for misleading information or misleading advertising. Beneficiaries enrolling in an MA plan should be able to make the most informed decision based on their individual health conditions and select a plan that best meets their health care needs. However, when MA plans advertise supplemental benefits as though all enrollees will be able to access them, withholding the information that enrollees must actually qualify for certain benefits, it is misleading and can result in enrollees joining a plan that actually does not best serve their needs. A plan's limited network or utilization management tools could result in delays or unmet health needs that can have catastrophic consequences.

Agent Broker Compensation (p. 78551)

[13] See, e.g. our comments to the 2022 *Medicare & You* Handbook (Sept. 2021): https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d; also see our MA RFI comments (Aug. 2022): https://medicareadvocacy.org/wp-content/uploads/2022/09/MA-RFI-Comments-2022.pdf.

Noting that Section 1851(j) of the Social Security Act "requires that CMS develop guidelines to ensure that compensation to agents and brokers creates incentives to enroll individuals in MA plans that are intended to best meet their health care needs" (p. 78477), CMS is "proposing to generally prohibit contract terms between MA organizations and agents, brokers or other third party marketing organizations (TPMOs) that may interfere with the agent's or broker's ability to objectively assess and recommend the plan that best fits a beneficiary's health care needs; set a single compensation rate for all plans; revise the scope of items and services included within agent and broker compensation; and eliminate the regulatory framework which currently allows for separate payment to agents and brokers for administrative services" (p. 78477). CMS also proposes to make conforming changes to Part D agent broker compensation rules. CMS states that "[c]ollectively, we believe the impact of these proposed changes will better align with statutory requirements and intent: to ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the plan that best fits a beneficiary's health care needs" (p. 78477).

The Center agrees that additional payments to agents and brokers beyond commissions are problematic and further skew enrollment towards certain MA plans. For example, we discussed plan sponsor incentive payments, health assessments and the sale of ancillary health products in *CMA Alerts* last fall.[14] We agree that add-on payments to agents/brokers should be prohibited and that MA plans should not be able to provide additional compensation to agents and brokers to complete health risk assessments, which further incentivizes agents and brokers to sell MA over other products. We therefore strongly support CMS' proposals as outlined in this proposed rule. However, as discussed below, we assert that CMS must also: 1) expand the scope of the proposal and go farther to ensure that the intent of this proposal is not circumvented; and 2) apply a uniform commission rate across MA and Part D.

Expand Scope and Enforcement of Proposal

We strongly support the intent of this proposal, but are concerned that agents, brokers, third party marketing organizations (TPMOs) and other interested parties will circumvent the rules and still receive additional payments that will influence the plans they promote and steer people towards. For example, the Center has already heard of brokerage firms planning to set up a separate limited liability corporation (LLC) that is eligible to receive such payments (for, e.g., health risk assessments or case management).

Proposed 42 C.F.R. §422.2274(c)(5) would require TPMOs to "Ensure that no provision of a contract with an agent, broker, or other TPMO has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary." However, it seems possible that TPMOs still could receive incentive payments from plan sponsors through more of a vendor-client relationship. If such post-enrollment activities are performed by someone other than the selling agent, would such restrictions apply? Would the TPMO still be able to receive renumeration that could then be distributed to selling agents and brokers?

[14] See https://medicareadvocacy.org/ma-misconduct/ and https://medicareadvocacy.org/ma-and-selling-extra-products/.

Further, the Center is aware that commissions or other payments are sometimes made to agents and brokers that appear to be beyond the scope of CMS oversight (including this current proposal), but merit additional scrutiny and oversight. For example, it is our understanding that certain risk-bearing providers or entities such as Accountable Care Organizations (ACOs) or other value-based care arrangements/organizations may pay agents or brokers (or others) to steer beneficiaries towards certain providers for purposes of alignment or attribution, raising concerns about, among other things, free choice of providers in traditional Medicare.

CMS should focus on both the source and receipt of payment. We urge CMS to expand the focus of this rule to include payments from plan sponsors, and include payments from risk-bearing providers, and to make it clear that the rule applies to payments to agents/brokers regardless of whether it comes from an MA or Part D plan sponsor or other entity or provider (including ACOs).

Make Commissions Uniform Between MA and Part D

One major driver of inappropriate steering towards MA plans is the disparate commission rates paid for MA enrollments vs. other Medicare products, such as Part D plans and Medigaps. As noted in a February 2023 Commonwealth Fund report,[15] agents and brokers report being paid more to enroll people in MA than in traditional Medicare, by some reports three times as much. Payments are also higher for new enrollments as opposed to renewals, which incentivizes churning of enrollment. When it comes to Part D, agents report that a lot of carriers don't pay at all for Part D enrollments. Overall, "[c]ommissions for stand-alone Part D plans were viewed as too low and not worth the time". Further, "[a]ll brokers and agents who have served people dually eligible for Medicare and Medicaid said they enroll them in Special Needs Plans only." The report also highlighted extra income that agents can earn from conducting beneficiary health risk assessments and bonus payments for reaching enrollment benchmarks.

In addition to the financial incentives insurance companies have to maximize profitable enrollment in MA plans, skewed commissions and other payment incentives drive agents and brokers to push people towards MA plans and away from traditional Medicare. **Thus, we urge that agent and broker commissions for MA and Part D plans be equalized across the board – one uniform commission for Part D and MA products alike**. While insurance and broker industry representatives might argue that the current commission structure accounts for the difference in payment and scope of coverage between MA and Part D plans, and that agents/brokers spend a lot more time reviewing and discussing MA options than they do Part D, we assert that is if an agent/broker is doing a thorough, comprehensive counseling session with a beneficiary, the discussion should focus on both MA and Part D and all of the corresponding variables to consider, thus a flat commission between the two is reasonable. While we support CMS' proposal to apply these new rules to Part D plans as well, as long as MA commissions are considerably higher than Part D commissions, incentives to push MA products over stand-alone PDPs remain.

[15] https://www.commonwealthfund.org/publications/2023/feb/challenges-choosing-medicare-coverage-views-insurance-brokers-agents

Suggestions for Additional Marketing and Communications Changes

The Center is grateful to CMS for the marketing changes implemented in the final 2024 Part C & D rule, along with the proposals outlined in the current rule. In order to adequately protect Medicare beneficiaries from marketing misconduct, however, more action must be taken.

On October 18, 2023, the Senate Finance Committee held a hearing entitled "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences". Following the hearing, the Senate Finance Committee Democrats sent a letter[16] to CMS on October 25, 2023, urging further action concerning deceptive Medicare Advantage marketing scams. The letter urges the agency to limit third-party marketing organizations (TPMOs) from selling individuals' personal information; require MA plans to provide a broker's identity when a beneficiary submits an enrollment related complaint through Medicare's complaint tracking system; increase transparency around marketing spending in the MA program; and "review the agent and broker compensation model to ensure a level playing field for plan participants in the MA program." CMS has only proposed to address this last issue – in part – in the current proposed rule. We urge CMS to address the other issues raised by the senators: TPMOs' sale of personal information (which CMS proposed to do in the 2024 Part C & D NPRM, but inexplicably neither finalized the proposal nor addressed it in the current NPRM); proving a broker's identity when a CMT complaint is filed; and increase transparency around marketing spending by MA and Part D plans.

In addition, we urge both Congress and CMS to take additional steps to rein in marketing abuses and provide a more level playing field between MA and traditional Medicare, as outlined in our submitted written testimony[17] to the Senate Finance Committee hearing referenced above. We refer CMS to this testimony concerning efforts to continue to rein in wasteful overpayments to MA plans, further strengthening oversight and enforcement, and fostering informed decision-making on the part of Medicare beneficiaries, including standardizing MA benefits and limiting plan offerings by sponsor and investing further in the nationwide State Health Insurance and Assistance Program (SHIP) as a critical source of unbiased information about the Medicare program and coverage options.

CMS has made significant improvements in marketing rules in recent regulatory updates. Notably, as mentioned above, the final Part C & D rule for 2024 brings some needed consumer protections.[18] But this work is not done – more is needed in order to adequately protect Medicare beneficiaries from unwanted, often misinforming, and sometimes harassing sales pitches. Among other things, CMS should:

- Prohibit contacts due to pre-existing relationships (from both agents/brokers and insurance plans – e.g. Part D plan sponsor calling a current enrollee to convince them to enroll in the same sponsor's MA product)
    - CMS did tighten rules regarding opt-out from contact but didn't go far enough. We often hear about individuals enrolled in a stand-alone Part D plan

[16] https://www.finance.senate.gov/imo/media/doc/post-hearing_cms_ma_marketing_middlemen_letter.pdf
[17] https://medicareadvocacy.org/center-testimony-for-senate-hearing-on-ma-marketing/
[18] See, e.g. a summary of these rules in a CMA Special Report: https://medicareadvocacy.org/c-and-d-rule-2023/

being contacted by the plan sponsor in an attempt to get the individual to switch to one of the sponsor's Medicare Advantage products. This is not a solicited contact, rather it is a cold call, and has nothing to do with the provision of care or benefits of an individuals' current coverage, and therefore should be prohibited. In other words, CMS should prohibit plan sponsors from calling current members to discuss Medicare products. At the very least, members should be able to opt-in to receiving such contact rather than having to actively opt-out under current rules (even if they are notified at least annually under CMS' proposal).
    - CMS proposed a 6-month time period limit for contact after Scope of Appointment (SOA) or Business Reply Card (BRC) filled out but finalized a 12-month period. This should be shortened to 3 months, or the current enrollment period.
- Prohibit cross-selling of other health related products during the sale of MA and Part D plans
    - In marked contrast to the proclamations of the insurance industry, many of the same people selling Medicare Advantage products both highlight and rely upon MA products' shortcomings in order to promote the sale of ancillary products.[19]
    - Under current Medicare marketing rules, MA organizations may not "Market non-health care related products to prospective enrollees during any MA sales activity or presentation. This is considered cross-selling and is prohibited." 42 CFR §422.2263 (b)(4). This regulation has such a limited definition of "cross-selling" that it allows a broad range of exploitative behavior, including the sale of ancillary health products during MA sales.
- Prohibit collection of Business Reply Cards (BRCs) or other information during educational events
- CMS should revisit the distinction between "marketing" and "communications" and corresponding requirements. We disagree with the agency's assertion that documents that may impact an enrollment decision, but are not intended to do so, don't qualify as marketing documents. If a beneficiary uses a plan-issued document to make enrollment choices, the sponsor's intent is irrelevant. Plan- and agent/broker-issued content should be subject to stringent oversight by CMS to ensure accuracy and readability.
- Address Marketing of supplemental benefits, particularly SSBCI that might not be available to everyone in a given plan (as discussed above)
    - We have heard from SHIP programs that in some areas, the top issue that drove people to seek SHIP counseling during the last annual enrollment period were plan-issued debit cards, or flex card benefits. People demanded to be enrolled in the plan that offered the most money, disregarding other considerations. One example provided by a SHIP counselor concerned a client who discovered that none of the five providers she was currently seeing were in network of the plan that offered the highest value debit card she sought. At the beginning of the year, the same SHIP programs report that one of the top issues they have heard about from beneficiaries was how such debit or flex

[19] See, e.g., CMA Alert: https://medicareadvocacy.org/ma-and-selling-extra-products/

cards don't, in fact, work as the beneficiary was led to believe by the plan or agent/broker.

- Further strengthen new requirements re: explaining the effect of an individual's enrollment choice on current coverage
    - Pre-Enrollment Checklist (PECL) – needs to address prior authorization; needs to inform beneficiaries that providers can leave/be terminated from network mid-year; should be an articulation of the right to seek care outside of a plan's network when an in-network provider or benefits is unavailable or inadequate to meet an enrollees' medical needs.
- Require that agents and brokers sign an attestation form that whatever product is being sold is appropriate for that beneficiary. Such an attestation is currently required for the sale of Medigap (Medicare supplemental insurance policies).
- Finalize the rule (proposed, but not finalized in the 2024 C&D rule) that personal beneficiary data collected by a TPMO may not be distributed to other TPMOs (as referenced above).

VIII. Improvements for Special Needs Plans (p. 78562)

The Center shares CMS's goal of promoting integration for dually eligible individuals by creating more opportunities for duals to enroll specifically in integrated plans. The Center strongly supports allowing dually eligible individuals and LIS recipients to make enrollment choices on a monthly basis. We support eliminating the dual eligible quarterly special election period (SEP) and creating a new monthly dual eligible SEP for standalone Part D plans (PDP).

A newly proposed integrated SEP would allow dually eligible individuals to enroll into integrated Medicare Advantage plans on a monthly basis. Specifically, the proposed integrated care SEP would allow dually eligible individuals to enroll into a FIDE-SNP, HIDE-SNP, or AIP (or change from a non-integrated plan or between these integrated plan types). The SEP would not allow for enrollment into coordination only-DNPs or other non-integrated Medicare Advantage plans. Individuals could only enroll in these non-integrated plan types during an individual's initial enrollment period, the annual election period, the Open Enrollment Period or where another SEP permits. We also support this proposal for the creation of an integrated SEP that would allow dually eligible individuals to enroll into integrated Medicare Advantage plans on a monthly basis.

We agree that dually eligible beneficiaries would benefit from monthly opportunities to make changes to their integrated plans. We understand the motivation for eliminating the quarterly SEP for duals enrolling in non-integrated plans and for limiting enrollment in those plan types to an individual's initial enrollment period, the annual election period, the Open Enrollment Period or where another SEP permits. While we generally advocate for more enrollment opportunities instead of fewer opportunities, we know that these non-integrated plans often do not coordinate care and can be difficult for beneficiaries to navigate. We urge CMS to limit those plan types in conjunction with limiting the enrollment opportunities. Our concern is that beneficiaries might not understand why they can no longer enroll and they might not be aware of additional enrollment opportunities for the coordinated plan types, as well as the enhanced coordination in

the other plans. Without robust communication and oversight of plans, limiting enrollment periods could lead to unintended consequences and confusion.

Additionally, we support the changes in the proposal aimed at increasing integration of Medicare and Medicaid and simplifying choice. The proposal would require, beginning in plan year 2027, D-SNPs that also operate a Medicaid managed care plan in the same service area as the D-SNP must limit new enrollment to individuals in the D-SNP to those enrolled in the affiliated Medicaid managed care plan. By plan year 2030, these D-SNPs can only have individuals enrolled in the D-SNP that are also enrolled in the affiliated Medicaid plan and would have to disenroll individuals who are not in an affiliated Medicaid plan.

We also support the proposal that CMS will only contract with one D-SNP with an affiliated Medicaid managed care plan that is operated by the same Medicare Advantage organization or parent organization offered in a service area as the aligned Medicaid managed care plan. This would limit the number of D-SNPs offered by the same company in the same service area, while allowing for exceptions.

We support limiting the number of D-SNPs offered by the same organization, as we know that the number of Medicare Advantage plans available to choose from create "choice overload" for beneficiaries and can be confusing and make it difficult to select the best plan for an individual. We also stress how non-integrated Medicare Advantage plans cause coordination problems for beneficiaries including improper billing and can create barriers to Medicaid covered services like dental care. We also urge CMS to limit the number of coordination only D-SNPs offered by the same parent organization operating in the same service area.

I-SNP Network Adequacy (p. 78564)

CMS proposes new network adequacy rules that would be applicable solely to Institutional-Special Needs Plans (I-SNPs), a subcategory of Medicare Advantage (MA) plans that restrict eligibility to MA-eligible individuals who meet the definition of institutionalized in §422.2 – residing in a skilled nursing facility (SNF) or expected to reside continuously in a SNF for 90 days or more. The proposal broadens the exceptions to current network adequacy requirements, solely for I-SNPs, based on the I-SNP industry's argument that residents of skilled nursing facilities get most of their care within the facilities and typically do not leave their facilities for care. CMS specifically proposes two ways that I-SNPs would be able to request special exemptions from network adequacy requirements: (1) showing that they are unable to contract with outside providers (for example, by submitting letters from outside providers indicating that they decline to contract with the I-SNP); and (2) adding telehealth benefits for I-SNP participants.

CMS acknowledges that its proposal comes directly from the I-SNP industry, which argues that I-SNPs have difficulty contracting with outside providers. Indeed, in its February 23, 2023 comment letter on CMS-4201-P,[20] the American Health Care Association (AHCA) explicitly

[20] https://www.ahcancal.org/News-and-Communications/Fact-Sheets/Letters/AHCA_NCAL%20Comments%20CMS-4201-P_CY2024%20MA%20and%20Part%20D%20Proposed%20Rule_Final.pdf#search=I%2DSNP

asked CMS to "right-size network adequacy requirements to reflect typical patterns of care for I-SNP beneficiaries." AHCA contended in its comment letter that changing network adequacy rules for I-SNPs would promote "beneficiary access, meaningful competition, and enhanced primary care." These glowing comments are in sharp contrast to what AHCA says internally about the value of I-SNPs. Internally, AHCA stresses the financial benefits to facilities of I-SNPs.

AHCA describes forming a Population Health Management (PHM) Council in 2019 in order "to convene and support long LTC providers who are leading in PHM initiatives through advocacy, education, and quality improvement data."[21] AHCA identifies four "Council Partners" – AllyAlign Health, American Health Plans, Longevity Health Plan, and PHHP – "whose sole or primary purpose is to partner with LTC providers to support LTC provider ownership interests in PHM models."[22]

These Partners make clear that nursing homes' interest in operating I -SNPs is financial. On AHCA's website, American Health Plans writes:

> American Health Plans' provider-owned I-SNPs allow nursing home owners and operators to take control of the LTC residents and realize 100 percent of the shared savings associated with execution of the model of care.
>
> * * *
>
> **Facility level financial returns: 100 percent shared savings**
>
> For too long, the concept of risk-based reimbursement meant an upside to other providers and a downside for nursing home owners and operators. American Health Plans has changed that dynamic. Their members are your residents and 100 percent of the shared savings generated through great clinical results is paid to the nursing facilities. These are savings your facility has earned. American Health Plans ensures you keep them within the facility.[23]

The piece concludes:

> **American Health Plans: control your future by controlling the Medicare premium**
>
> As nursing home owners themselves, American Health Partners appreciates the challenges of clinical resources and cash flow. However, their experience owning and operating Medicare Advantage Plans since the inception of the program in 2004 has allowed them to realize the clinical and financial power of controlling the Medicare

[21] AHCA, Population Health Management, https://www.ahcancal.org/Reimbursement/Pages/Population-Health-Management.aspx
[22] AHCA, Population Health Management, https://www.ahcancal.org/Reimbursement/Pages/Population-Health-Management.aspx
[23] AHCA, American Health Plans, https://www.ahcancal.org/Reimbursement/Documents/PHM/American%20Health%20Plans%20Overview.pdf#search=I%2DSNP.

premium for their nursing home residents. They want to partner with you to bring the clinical program and financial upside to your facilities as well.

Medicare Payment Advisory Commission (MedPAC)

MedPac reported in its March 2023 *Report to Congress on Medicare Payment Policy* that in 2021, I-SNPs had average margins of 4.0% (compared to for-profit MA plans' average margins of 2.8%).[24]

I-SNPs have dramatically increased in number, nearly doubling from 97 plans in 2018 to 189 plans in 2023. [25] Nevertheless, despite the increase in I-SNPs and their profitability, MedPAC has not discussed I-SNPs since 2013. In 2013, MedPAC supported permanent reauthorization of I-SNPs, but made two disturbing comments about the care provided by I-SNPs.[26]

First, MedPAC found that I-SNPs "have higher rates than regular MA plans for the use of potentially harmful drugs among the elderly and the use of drug combinations with potentially harmful interactions." Report 322. MedPAC excused these higher rates of inappropriate drugs and drug combinations by noting "their higher rates of monitoring of persistently used drugs suggest that drugs with potential interactions or adverse effects are also being closely monitored." *Id.* Additional monitoring is not reassuring when residents continue to receive inappropriate drugs.

MedPAC's only other comment is the note that I-SNPs have "fewer hospital readmissions than would be expected given the clinical severity of their enrollees." *Id*. MedPAC then leaps to the conclusion that "I-SNPs' performance in hospital readmissions rates is an important measure of whether they provide a more integrated delivery system." *Id.* That conclusion is not necessarily true. I-SNPs may simply be denying hospitalization for residents who need to be hospitalized or not paying for residents' hospital care. MedPAC's only support for its conclusion is the statement, without supporting evidence, that "I-SNPs attempt to reduce hospital and emergency department utilization through care management and by emphasizing the provision of primary care." *Id*.

These observations by MedPAC about inappropriate medication use and fewer hospitalizations suggest that more beneficiary protection is needed, as discussed below.

Center for Medicare Advocacy's Concerns about I-SNPs

I-SNPs are Medicare Advantage plans, which means that they are responsible for all of the health care costs of their members that they cover. The I-SNP receives the full Medicare payment for

[24] MedPAC, *Report to the Congress: Medicare Payment Policy*, p. 339 (Mar. 2023), https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf
[25] AHCA, "Medicare Advantage Plan Challenges – Media Spotlight," https://www.ahcancal.org/Reimbursement/Medicare/Documents/MA%20Media%20Summaries/MA%20Plan%20Media%20Summary%20February%202023.pdf#search=I%2DSNP.
[26] MedPAC, *Report to the Congress: Medicare Payment Policy*, Chapter 14, "Medicare Advantage special needs plans" (Mar. 2013), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-14-medicare-advantage-special-needs-plans-march-2013-report-.pdf

plan enrollees and controls whether and how Medicare dollars are spent. The CEO of AllyAlign, one of the partners identified by AHCA as a company helping providers, including SNFs, implement provider-sponsored managed care plans, described the model in 2019: "The construct is to grab the [Medicare] premium dollar directly if you're an LTC provider, and then manage in the best interests of the patient. That also tends to be the best economic model as well."[27]

When the I-SNP is owned by the nursing home, there is an inherent conflict of interest because the plan, acting as an insurer, can deny coverage of expensive care, even including care in its own skilled nursing facility.

In 2017, *Kaiser Health News* highlighted the conflict of interest in a report about an Erickson Living continuing care retirement community (CCRC) in Maryland, which had an I-SNP, called Erickson Advantage, solely for its community's residents. Kaiser described a resident in the retirement community, who was sold an Erickson Advantage plan by an Erickson nurse. After the woman returned to the community from the hospital, the I-SNP limited, and then denied, Medicare coverage of her stay in the SNF part of the CCRC.[28] Although the Erickson Advantage plan reversed its noncoverage decision after being contacted by the reporter, *Kaiser Health News* described the experience of a second resident with an Erickson plan in Massachusetts, who similarly had her SNF coverage limited by the Erickson plan. After 11 days in the community's SNF, the 98-year-old resident was charged a daily rate of $463 (later increased to $483) for her SNF stay. *Kaiser* reported that an administrative law judge upheld the Erickson plan's determination that the woman's SNF stay was not covered by Medicare, "based on the testimony from the nursing home staff – all Erickson employees." At the time of the *Kaiser* article, the CCRC's bill for the enrollee resident's SNF stay was $30,000, and increasing daily.

Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services From the Same Organization (p. 78566)

"We are proposing interconnected proposals to (a) replace the current quarterly special enrollment period (SEP) with a one-time-per month SEP for dually eligible individuals and others enrolled in the Part D low-income subsidy program to elect a standalone PDP, (b) create a new integrated care SEP to allow dually eligible individuals to elect an integrated D–SNP on a monthly basis, (c) limit enrollment in certain D–SNPs to those individuals who are also enrolled in an affiliated Medicaid managed care organization (MCO), and (d) limit the number of D–SNP plan benefit packages an MA organization, its parent organization, or entity that shares a parent organization with the MA organization, can offer in the same service area as an affiliated Medicaid MCO. This proposed rule would increase the percentage of dually eligible MA enrollees who are in plans that are also contracted to cover Medicaid benefits, thereby expanding access to integrated materials, unified appeal processes across Medicare and Medicaid, and continued Medicare services during an appeal. It would also reduce the number of plans overall that can enroll dually eligible individuals outside the annual coordinated election period, thereby

[27] Maggie Glynn, "AllyAlign CEO: I-SNPs Will Form 'Permanent Pillar' in Changing Skilled Nursing World," *Skilled Nursing News* (Jan. 27, 2019), https://skillednursingnews.com/2019/01/allyalign-ceo-i-snps-will-form-permanent-pillar-in-changing-skilled-nursing-world/

[28] Jordan Rau, *Kaiser Health News*, "Nursing Homes Get Into the Insurance Business," *U.S. News & World Report* (Jul. 12, 2017), https://www.usnews.com/news/healthcare-of-tomorrow/articles/2017-07-12/nursing-homes-get-into-the-insurance-business.

reducing the number of plans deploying aggressive marketing tactics toward dually eligible individuals throughout the year." (p. 78478)

Contracting Standards for Dual Eligible Special Needs Plan Look-Alikes (p. 78578)

The Center strongly supports the proposal to lower the percentage threshold of dual eligible enrollment to 70% in contract year 2025 and 60% starting in contract year 2026. We have expressed our concerns for many years over the dangerous consequences of D-SNP look-alike plans targeting and serving dual eligibles without the safeguards, state oversight, or stakeholder input involved in regulation and oversight of D-SNPs and other integrated delivery models. This proposal builds on the improvements made by CMS In 2021 to limit look-alikes specifically not entering into or renewing contracts with Medicare Advantage plans, that are not D-SNPs, where enrollment of dually eligible individuals is 80% or more. We strongly support the proposal to further lower this threshold as we know that look alike plans continue to target dually eligible individuals.

We agree with CMS that this proposal would help address the continued proliferation of MA plans that are serving high percentages of dually eligible individuals without meeting the requirements to be a D–SNP.

For D–SNP PPOs, Limit Out-of-Network Cost Sharing (p. 78583)

"We are proposing 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." (p. 78478)

Conclusion

We appreciate the opportunity to submit these comments. For additional information, please contact Senior Policy Attorneys David Lipschutz, dlipschutz@MedicareAdvocacy.org, or Kata Kertesz, kkertesz@medicareadvocacy.org, and at 202-293-5760.

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