JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

April 24, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Sent electronically via email to: PartCDcomments@cms.hhs.gov

Re: 2017 Transformation Ideas

Justice in Aging appreciates the opportunity to respond to the Request for Information (RFI) that accompanied release of the 2018 Advance Notice of Methodological Change and the 2018 Call Letter for Part C and Part D Plans.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

General Principles. As beneficiary advocates, we appreciate the efforts over the years by CMS to improve beneficiary communications, to ensure network adequacy and to strengthen plan accountability. Our comments are focused primarily on how to strengthen and support these efforts. We ask that CMS, in considering improvements to the Part C and D programs, always give primary consideration to how any change will affect the beneficiaries, particularly whether it will be easier or harder for the beneficiary to navigate and whether the beneficiary will have greater or lesser access to services.

Our comments fall into three primary areas:

1. Simplifying information for beneficiaries and improving beneficiary supports;
2. Increasing program efficiency and protecting beneficiaries;
3. Increasing transparency and engagement.

1. Simplifying information for beneficiaries and improving beneficiary supports

Language Access. We urge CMS to improve communications with individuals with limited proficiency in English. Such improvements would serve the goals of transparency, supporting the doctor-patient relationship in care delivery and facilitating individual preferences, all identified in the RFI. Improvements would also address the agency's goal of reducing health disparities.

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- *Expand the categories of documents subject to the translation requirements.* We ask that CMS, using the current translation requirements for marketing materials found at 42 CFR 422.2264(e) and 42 CFR 423.2254(e) as a starting point, expand the categories of documents for which translation into non-English languages is required. We recommend specifically that, at a minimum, translation requirements be extended to: all plan communications directly relating to the start, denial, or cancellation of enrollment; all plan communication related to the denial, limitation or expiration of coverage for any services or prescription drugs; and all plan communication directly related to receipt of the low income subsidy.

  Under longstanding interpretations by HHS of Title VI obligations and more recent regulations enforcing Section 1557, HHS has identified "vital" documents and a larger category, "significant" documents, as among those which are most susceptible to a translation requirement.[1] Notices that directly affect access to services, either through plan enrollment, service denials or limitations to subsidy benefits clearly fit in those categories. CMS, as the primary regulator of plans, has already given them specific requirements for translation of marketing materials. By expanding the types of documents that are subject to the translation requirement, CMS would both assist plans in compliance with Title VI and Section 1557 obligations and promote health equity, in accordance with the CMS Equity Plan for Improving Quality in Medicare.[2]

  We also note that many states routinely require Medicaid managed care plans to translate far more documents to their enrollees and plans have done so routinely.[3] The process has been in place for years and has not been overly burdensome.

- *Add numerical thresholds to the percentage thresholds for translation.* Currently translation for marketing documents is required for languages spoken by five percent or more of the population in the plan service area. We ask that CMS adopt regulations which provide that translation requirements are triggered if a non-English language is spoken either by a percentage or by an absolute number of people in the service area. We further propose that, for purposes of counting absolute numbers, the service area be determined by combining all service areas served by the plan sponsor. These changes would address two major anomalies created by the current regulations. First, though PDPs in states like New York or California with large populations may serve tens of thousands of LEP individuals speaking a non-English

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[1] See Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, 65 Fed. Reg. 52762, 52767, note 6 (Aug. 30, 2000), available at www.gpo.gov/fdsys/pkg/FR-2000-08-30/pdf/00-22140.pdf and 81 Fed. Reg 31376, 31402 (May 18, 2016), available at https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf.

[2] See The CMS Equity Plan for Improving Quality in Medicare, Priority 5, Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities, available at https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf.

[3] See, for example, Ca. Dept. Health Care Serv., Standards for Determining Threshold Languages (Aug 27, 2014), available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-008.pdf (requiring all "member informing" material be translated into threshold languages).

language, the five percent threshold is not triggered because the population base against which the threshold is calculated is so large.[4] Second, the current threshold does not take into account the reality that both the PDP market and the MA market are dominated by large national plan sponsors. These plans easily serve many thousands of speakers of Chinese, Vietnamese, Korean and other common languages yet may have no obligation to translate model documents in these languages.[5] By any balancing of equities, the burden on plans is minimal compared to the benefits of access and transparency for plan members.

Personalize the ANOC. In the market-based Part C and Part D programs, the most important annual mailing to beneficiaries is the Annual Notice of Change (ANOC). The ANOC is meant to set the stage for the beneficiary to start considering whether to change plans. An effective ANOC needs to be clear, relatively short and, most importantly, must highlight for the individual the core changes in plan coverage. We urge CMS to develop a personalized flexible ANOC that would achieve these goals. Based on the individual's prescription drug history, the ANOC would highlight changes in prescription drugs covered or available network pharmacies. The ANOC would also be tailored to the individual's LIS status and would not simply refer the individual to the LIS rider. Because it would not contain extraneous information and would instead hone in on what is specifically relevant to the consumer, a tailored ANOC would be much clearer and more concise.

Simplify Benefit Design. We ask that, in considering any innovation in benefit design, CMS first evaluate whether the change will simplify beneficiary choice and whether it will narrow beneficiary access. On the Part D side, plan designs, usually with five tiers, with preferred and non-preferred pharmacies and often with combinations of fixed and percentage co-payments are very confusing. We urge CMS to steer away from any further complications and to use its flexibility to seek design changes that make things simpler for beneficiaries.

On the Medicare Advantage side, one area of complexity that advocates find of concern is plan delegation. This practice allows a plan to require that members only use providers within their Primary Care Provider's subnetwork. Thus, in order to see a specialist who is in the plan's network but not in the PCP's subnetwork, the beneficiary would need to change to a new PCP. This restriction is very difficult to communicate to beneficiaries. Further, many Medicare beneficiaries have multiple complex conditions and heavily rely on specialist care. Limitations to delegated networks can severely limit access to care, putting a beneficiary in the difficult position of needing either to change PCP or forego

[4] In California, for example, there are 610,000 LEP Chinese speakers yet PDPs serving California have no translation obligation. See Resource for Entities Covered by Section 1557 of the Affordable Care Act Estimates of at Least the Top 15 Languages Spoken by Individuals with Limited English Proficiency for the 50 States, the District of Columbia, and the U.S. Territories, available at www.hhs.gov/sites/default/files/resources-for-covered-entities-top-15-languages-list.pdf

[5] According to Census figures, in the United States there are over 1.72 million limited English proficient Chinese speakers, 859,000 LEP Vietnamese speakers, and 613,000 LEP Korean speakers. See https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_B16001&prodType=table

the opportunity to consult a particular in-network specialist. We ask CMS to reconsider its current policy of allowing this level of delegation. We recognize that encouraging beneficiaries to choose providers who work together can have advantages, but we ask CMS to prohibit network designs that mandate limitations to access. Any plan member should be able to use the services of any in-network provider.

Support and expand State Health Insurance Programs (SHIPs). If Part C and D are to work as envisioned, empowered consumers must be making informed market choices. With programs as complex as Medicare Part C and Part D, Medicare beneficiaries need knowledgeable and unbiased one-on-one assistance to make such choices. The 3,000 local SHIP offices with their 15,000 counselors provide just such assistance. SHIP counselors, besides helping with plan choices, also assist beneficiaries when they run into difficulties in accessing benefits, have billing questions or otherwise experience problems in using their plans. Because of the expertise of SHIP programs, many issues are resolved quickly, saving time and money for CMS, plans and, most especially, beneficiaries. SHIP counselors importantly help low income beneficiaries to apply for the Low Income Subsidy and other needed assistance. They also are on the front line in working to identify and prevent Medicare fraud. Perhaps most importantly, SHIP counselors, because they offer extended in-person and telephone assistance (averaging 50 minutes per client), are able to give beneficiaries the tools and the confidence to effectively navigate their benefits over the longer term. This kind of skilled hands-on assistance simply cannot be provided by 1-800-MEDICARE, websites or written materials.

We are very concerned about proposals that would eliminate SHIP funding. This action seems particularly ill-considered in light of the fact that SHIPs are staffed primarily by volunteers. We strongly urge CMS and HHS to reconsider support for these proposals and, instead, expand and strengthen SHIPs. The need is great. SHIP programs assisted millions of people last year. They have proven themselves as highly cost effective programs and should be expanded and strengthened to better handle the influx of retiring baby boomers in the next several years.

2. Increasing program efficiency and protecting beneficiaries

Encourage more frequent submission of data from state Medicaid programs. We continue to receive reports from advocates that beneficiaries who are newly dual eligible or newly have qualified for Medicare Savings Programs have difficulties getting appropriate subsidies or have not been auto-enrolled in a Part D plan. Although the LI-NET system and the Best Available Evidence policy have both helped to alleviate these problems, the issues persist. A core cause of these problems is the continued lag between the state Medicaid enrollment date and notification to CMS and plans.

We appreciate that some years ago CMS encouraged states to submit enrollment files as frequently as daily and revamped its own system to provide quick turnaround. Most states, however, have not fully taken advantage of the opportunity for more frequent transfer, with most only submitting files twice a month.

To our knowledge, after its initial engagement with states, CMS has not revisited the issue. We urge CMS to once again reach out to states and work with them on establishing more frequent schedules of file transfer. Such an effort would be particularly timely in light of the new CMS procedure, part of its initiative to prevent improper billing of QMBs, whereby a beneficiary can check on his QMB status through 1-800-MEDICARE. Data transfer improvements would increase the accuracy of the information that the CSRs provide.

Develop strategies addressing payment of premiums by choosers. It has been longstanding CMS policy to reassign LIS recipients if their Part D plan loses benchmark status but not to do so for "choosers," instead sending them a letter each fall (the "tan letter") notifying them of the loss of benchmark status and explaining their choices. The unfortunate fact, as documented by a 2015 Kaiser study,[6] is that the tan letter has not been a highly effective tool in encouraging active choice. Very few choosers who face the imposition of premiums—only about 14 percent—change plans. Particularly concerning is the finding in the Kaiser study that "choosers" who remain in non-benchmark plans have tended to pay increasingly higher premiums over time.[7]

We ask that CMS, with full stakeholder participation, revisit its policy concerning treatment of choosers and explore whether more effective measures can be taken to protect this vulnerable group from unnecessary costs. Approaches to consider and possibly test could include:

- Testing reassignment of choosers who have not changed plans in several years
- Testing reassignment of choosers who are paying premiums above a particular cut-off point
- Sending tan letters to all choosers who are paying a premium. The present practice is to only send letters to choosers facing a premium increase for the current year.
- Providing information to SHIPs to help them conduct targeted outreach to choosers

Ensure Part D transition supplies when an exception expires. We ask CMS to address prescription drug protections for individuals who lose prescription drug access because an exception is expiring. Currently Section 30.4 of Chapter 6 of the Prescription Drug Benefit Manual provides that individuals with an expiring exception have the right to a one-time transition fill. CMS, however, overrode that directive with an August 19, 2016 memorandum distributed through HPMS that "clarified" that CMS does "not expect Part D sponsors to include expiring formulary exceptions in their transition policies." The reason for the reversal was plan readiness specifically that "plans will need to make significant system changes to implement this policy, particularly with respect to exceptions expiring mid-year."
We recognize the need to allow plan sponsors time to make systems change. We strongly urge CMS, however, to set a firm start date for this transition requirement.

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[6] J. Hoadley, L. Summers, E. Hargrave and S Stromberg, To Switch or Be Switched: Examining Changes in Drug Plan Enrollment among Medicare Part d Low-Income Subsidy Enrollees (Kaiser Family Foundation, July 2015) available at http://files.kff.org/attachment/report-to-switch-or-be-switched-examining-changes-in-drug-plan-enrollment-among-medicare-part-d-low-income-subsidy-enrollees

[7] Id at 12.

The requirement to apply transition rules to expiring exceptions is an important consumer protection and we had appreciated its clear inclusion in the January 2016 PDBM updates. Plan members, in order to have received an exception in the first place, have already shown the medical necessity of the drugs at issue. Given the already established importance of the drug to their health, it is critical that plan members have access to a transition supply while they pursue a fresh exception or move to a different medication.

Continue to address inappropriate billing of Qualified Medicare Beneficiaries (QMB)**.** We are most appreciative of the initiatives that CMS has taken to reduce illegal billing of QMBs, both in fee-for-service Medicare and in Part C plans. This work is very important. CMS has documented the severe impact of inappropriate billing on both the financial stability of these low income beneficiaries and on their access to care.[8] Advocates also continue to see these problems and the financial hardship and distress they cause.

In the 2017 Call Letter, CMS reminded plan sponsors of their obligation to prevent inappropriate billing by plan providers of members that are dual eligibles or QMBs. We believe the inclusion on the Call Letter significantly raised the visibility of QMB billing protections within plans and with plan providers. We thank CMS and ask that the agency continue to work with plans to share best practices in educating providers about QMB billing protections.

An area that also would benefit from continuing attention is identification of an individual's QMB status. We appreciate that CMS is implementing a program on the fee-for-service side that will show on remittance statements for QMBs that no further payment is due. We ask that CMS continue to work with plans to ensure that they also have systems in place that effectively provide similar information and instructions to providers.

3. Increasing transparency and engagement

Expand compliance monitoring of plans and increase transparency on enforcement actions. With almost a third of Medicare enrollees now in Medicare Advantage plans and the prescription drug benefit administered exclusively through private plans, it is imperative that CMS exercise robust oversight to ensure that these parts of the Medicare program actually deliver promised benefits to Medicare consumers. We appreciate the audit work that has been undertaken by the agency and especially want to thank CMS for the transparency shown both in its public report on audit findings as well in the enhancement of the plan finder and plan websites through inclusion of notices of intermediate sanctions.[9] Further, we greatly appreciate our ongoing dialogue with CMS and other consumer

[8] CMS, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)," (July 2015), available at: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf

[9] CMS, 2015 Part C and Part D Program Audit and Enforcement Report (Sept. 2016), available at www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-

advocates on how to make enforcement actions, including intermediate sanctions and civil money penalties, more transparent. We also appreciate the agency's efforts to determine the accuracy of network provider lists through independent review.[10]

Both the audit findings and the network review reveal, however, that serious deficiencies are widespread and the need for more—not less-oversight to ensure that plans live up to their contract obligations. We propose that CMS consider the following measures:

- Provide the Oversight and Enforcement Group with additional resources so that more audits can be conducted more regularly. In a 2015 proposed rule, CMS details the criteria by which it determines which MA and Part D plan sponsors are audited each year and acknowledged that limited resources allow the agency to perform annual audits on only 10% of plan sponsors—30 of 300.
- CMS also previously proposed but chose not to finalize a rule requiring plan sponsors to hire independent auditors. Given persistently poor audit results, namely involving appeals and grievances, we ask CMS to revisit this proposal.[11]
- Provide additional transparency when there is an intermediate sanction or civil monetary penalty by issuing a press release, particularly if the civil monetary penalty is significant. CMS had in the past issued press releases when it issued intermediate sanctions and we see no reason why the agency should not reinstitute that practice.[12] Further, we note that HHS routinely releases press releases concerning penalties paid for HIPAA violations, many for relatively small amounts.[13]
- With respect to civil monetary penalties, we urge CMS to announce such penalties when they are assessed and discontinue the current policy of waiting to post them all at once in February. The delays deny beneficiaries timely access to important information about the performance of their plan, even when that performance resulted in millions of dollars in penalties. Further, the bunching of releases has the practical effect of de-emphasizing the importance of any one

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Audits/Downloads/2015_C_and_D_Program_Audit_and_Enforcement-Report.pdf ; and Common Conditions, Improvement Strategies, and Best Practices based on 2013 Program Audit Reviews (Aug. 2014),available at www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/HPMS-Memo-Common-Conditions-Improvement-Strategies-and-Best-Practices-2013-Audits.pdf.

[10]CMS, Online Provider Directory Review Report, available at www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf

[11] See Part C and Part D Audit Report, *supra*, note 8.

[12] See, e.g., CMS, Medicare Issues Intermediate Sanction Notice to Aetna Insurance Company Medicare Health and Drug Plans (April, 2010), available at www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2010-Press-releases-items/2010-04-09.html and Medicare Imposes Marketing and Enrollment Suspension on Three Health and Drug Sponsors (Nov. 2010), available at www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2010-Press-releases-items/2010-11-19.html.

[13] See, for example, HHS Office of Civil Rights, No Business Associate Agreement? $31K Mistake (April 20, 2017), available at www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/CCDH.

penalty. If plans engage in conduct that merits sanction, one effect of that sanction should be public scrutiny.

- Continue verification of provider network availability.
- Use verification and review such as secret shopper surveys and similar techniques to identify areas where CMS could provide additional technical assistance to plans. We have concerns, for example, that plan call centers may not be prepared to respond to the kinds of questions that dual eligibles may ask about the relationship between their Medicare Advantage benefits and Medicaid.
- Collect and review samples of member files to learn more about how well plans are doing in their efforts to coordinate member care. The Medicare-Medicaid Coordination Office has begun doing this with some financial alignment demonstration plans and has found that it has led to productive discussions with the plans about improvement in person-centered care. This kind of deep but narrow dive complements collection of meta-data and provides a window that only a ground level look can offer.

Engage patients and advocates in innovation. Through the Centers for Medicare & Medicaid Innovation, CMS solicited input on and then finalized two health plan innovation models, the Medicare Advantage Value-Based Insurance Design (MA V-BID) model and the Part D Enhanced Medication Therapy Management (MTM) model. Should the agency explore additional innovation options involving MA and Part D plans, we urge CMS to create mechanisms to ensure that people with Medicare and their advocates are fully involved in the development, implementation, and evaluation of these models. Towards this end, we strongly encourage the agency to:

- Convene regular meetings of a consumer and patient advisory council;
- Create multi-stakeholder advisory panels on specific delivery and payment models;
- Involve beneficiaries and their advocates in Technical Expert Panels (TEPs);
- Solicit public comment on proposed model designs;
- Regularly engage beneficiaries and their advocates as new models are implemented;
- Publicly release all data, metrics, outcomes, and evaluation findings for each model;
- Enhance supports via 1-800-MEDICARE and State Health Insurance Assistance Programs (SHIPs); and
- Carry out beneficiary testing and readability reviews of patient-facing content for each model.

Thank you again for the opportunity to comment. If you need additional information, please do not hesitate to contact me at JGoldberg@justiceinaging.org.

Sincerely,

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