

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 6, 2015

VIA Electronic Filing: [AdvanceNotice2016@cms.hhs.gov](mailto:AdvanceNotice2016@cms.hhs.gov)

Andrew Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244

Dear Acting Administrator Slavitt:

Justice in Aging (formerly National Senior Citizens Law Center) is pleased to submit these comments on the draft 2016 Call Letter. Justice in Aging is a national organization that 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. Our Medicare advocacy focuses primarily on the impact of the program on low income older adults, particularly those dually eligible for Medicare and Medicaid coverage.

## **Attachments I & II: Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-For Service Growth Percentage for CY 2016 and Changes to Part C Payment Methodology for CY 2016**

We continue to support the Part C payment methodologies established by the Affordable Care Act (ACA), to reduce the significant overpayments to Medicare Advantage plans relative to the traditional Medicare program. These policies are critical to stabilizing the fiscal health of the Medicare program, and to ensuring efficient spending of taxpayer dollars. We urge CMS to stay the course and to make final its proposed MA payment rates.

## **Attachment VI: Draft Call Letter**

## **Bid Submissions (pp. 70 – 74)**

We support CMS's increased scrutiny and heightened requirement for accuracy and precision in bid submission, including increased specificity in describing the type of quantity limit that is reflected in the formulary submission.

We support CMS's reminders to plans about the limitations on and reporting obligations related to mid-year formulary changes. Yet, while we appreciate that current enrollees who are protected from certain mid-year formulary changes are not "affected" due to their grandfathered status, we are concerned about CMS reducing reporting requirements for this type of change. A beneficiary who is protected from a mid-year change may nonetheless be surprised by the changed status in the next plan year. We encourage CMS to require plans to notify individuals who took a medication and whose status changes mid-year, even if that change will not affect them during the current plan year.

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As an option to achieve this end, we strongly encourage CMS to consider adding personalized content to the Annual Notice of Change (ANOC). We urge this as a requirement but, in the short run, ask CMS to establish best practices among MA and Part D plans on how to communicate this information in a specific and individualized manner to their enrollees through the ANOC.

### **Good Cause Review (p. 74)**

We are supportive of CMS's transfer of primary responsibility to plans to effectuate reinstatements when good cause criteria for non-payment of premiums are met. We recognize that beneficiaries often reach out to their plan first in this situation. We also appreciate the proposal of to develop an oversight protocol and the agency's retention of authority to review both favorable and unfavorable decisions.

We have reservations, however, and urge CMS to vigorously exercise its oversight during the rollout of the new procedures. In addition, we are concerned that in a good cause review process, a plan's primary incentive might be to collect outstanding premium payment rather than ensuring an individual is provided with accurate information about the process, encouraged to gather supporting evidence substantiating a good cause argument, and shepherded through a timely review process. Ensuring objectivity in the review of these cases and equity among beneficiaries is critically important.

It also is essential that the 1-800-Medicare call center receives adequate training about this change to ensure that beneficiaries are not mistakenly misdirected or delayed in seeking good-cause reinstatement. For this issue, as all beneficiary concerns, there should be no wrong door. We urge CMS to develop capacity so that there can be warm handoffs for this and any other problem where 1-800-Medicare cannot directly provide assistance. There also should be protocols so that if beneficiaries contact 1-800-Medicare with complaints about a plan's handling of their request for reinstatement, CMS can capture and track the beneficiary's complaint.

Second, CMS should ensure that plans handle these requests appropriately, not only by evaluating plan systems, but also by auditing plan performance. As evidenced by findings of recent plan audits, there have been problems with Medicare Advantage and Part D plans conducting their current responsibilities in handling appeals: problems with adequately distinguishing between appeals and grievances; problems with adherence to applicable appeal timeframes; and problems with timely effectuation of decisions. These results suggest that both close monitoring and extensive technical assistance are needed if this new responsibility is to be handled effectively by plans.

Finally, we are concerned that plan billing errors will not be adequately captured in the Complaint Tracking Module (CTM) if plans are responsible for investigating the error and effectuating the reinstatement. We urge CMS to address this concern in the final 2016 call letter by requiring plans to report on the number of good cause reinstatements related to improper or incorrect plan billing practices.

### **Enrollment Eligibility for Individuals Not Lawfully Present in the U.S. (p. 76)**

We are disappointed that, as noted in the recently issued final C & D rule for 2016, because of notice provided to individuals as part of "existing processes" at the Social Security Administration (SSA) regarding potential changes to lawful presence status, CMS will not require any additional notice from the plans at the time of disenrollment. We ask that CMS monitor calls to 1-800 Medicare and contacts

to plans to determine whether, in fact, the existing processes provide adequate information to beneficiaries.

We are very supportive of CMS's intent noted in the final rule to establish a special enrollment period (SEP) to be outlined in sub-regulatory guidance in order to accommodate individuals who regain lawful presence status, and therefore eligibility for Parts C and/or D.

### **Making the Exceptions and Appeals Processes More Accessible to Beneficiaries (p. 76)**

Justice in Aging is a signatory to the joint comments submitted by the Medicare Rights Center concerning exceptions and appeals. We strongly endorse the recommendations and comments in the joint letter and incorporate them here by reference into our own comments.

We want to include one additional comment with respect to language access and the appeals process. As CMS looks at ways to strengthen appeal notices, we ask that the agency also consider imposing translation requirements on coverage determination notices. Because these notices directly affect meaningful access to services, they should certainly qualify as "vital documents" under HHS guidance interpreting Title VI requirements for recipients of agency funds and should be subject to translation requirements. See 68 Fed. Reg. 47311 (Aug. 8, 2003).

Currently CMS rules around translation requirements are limited to certain marketing documents and do not cover any documents related to denial of services. State Medicaid agencies have set translation requirements for coverage determination notices for Medicaid managed care plans and compliance has not proved to be an unreasonable burden on plans. It is time to afford similar protections to Medicare beneficiaries.

### **Enhancements to the 2016 Star Ratings and Beyond (pp. 81-82)**

#### *Integrated Star Rating System (p. 82)*

We appreciate that CMS is exploring an integrated Star Rating system for Medicare-Medicaid Plans participating in the capitated Financial Alignment Initiative. Ongoing development of tools that effectively evaluate participating plans and also convey information to potential enrollees in a format that they can use to make informed choices is an important element of the demonstration.

Exploring whether an integrated star rating system would work and what it would look like is an important task. We ask that stakeholders, including consumer advocates, be included in the process from an early stage. There will be particular challenges because of the differing design of the demonstrations across states.

It also is important that any integrated Star Rating development be in addition to, and not in place of, real time data and longer term evaluations of the demonstration. Transparency and timeliness of data reporting are both critically important so that all stakeholders, including advocates, policy makers, and regulators can evaluate the demonstration both for long term analysis and for mid-course corrections.

*Duals/LIS (p. 98)*

We are very appreciative that CMS is collecting data to address claims that LIS eligibility affects plan scores and that the agency is transparent in sharing the research that it has commissioned and received from stakeholders. CMS has indicated that research is ongoing and we applaud the agency for digging deeper to better understand how beneficiary characteristics and care quality interact and for maintaining focus on the goal of improving care for the highest need and poorest beneficiaries.

We have concerns, however, about the approach set out in the Call Letter which, while more research is undertaken, reduces the weight of seven measures (six in Part C and one in Part D for PDPs). We are concerned that CMS cites “immediate relief to plans with significant Duals/LIS enrollment” as a result of the reduced weights for these measures, while acknowledging that there is “uncertainty” regarding the cause of lower star ratings for plans with dual eligible populations. If CMS is uncertain of the cause and the relationship between this population and plan performance, the better course would be delay in making any changes to the program.

Decreasing the weight of measures that CMS has found to disproportionately impact dual eligible beneficiaries will in essence increase the Star Ratings for plans, without actually improving care for dual eligible beneficiaries in these areas.

We are aware that there are data to suggest real disparities in care based on socio-economic status. These differences are best resolved by identifying the factors causing the disparities and creating systems that work to improve care, rather than masking these differences through adjustments in performance scores. The data that will result from the implementation of the IMPACT Act will be essential for CMS in making determinations regarding quality assessment. We continue to urge CMS to review the results of the data that are collected and compiled as a result of this Act, prior to making changes to the Star Ratings program for the proposed measures, and any additional measures in the future.

**Program & Compliance Plan Audit Performance (p. 110)**

Like CMS, we have been disappointed and concerned about the often abysmal plan performance reflected in audit findings. We ask that CMS consider expanding this section to highlight some of the most common and important deficiencies found in audits.

We also ask that CMS consider publicizing more broadly the civil monetary penalties and enrollment sanctions levied on plans and that the agency announce in the final Call Letter that it intends to do so. We urge CMS to issue press releases routinely when monetary or enrollment sanctions are issued and to employ Regional Offices to ensure that the information is distributed to relevant local media outlets. We also ask that CMS require plans to prominently post notices of compliance actions or sanctions on their websites.

While we are appreciative that sanctions and penalties are posted and available on the CMS website, our concern is that the information rarely finds its way to the communities and beneficiaries where the plan operates. Few beneficiaries ever become aware of the deficiencies of the plan in which they are enrolled or considering enrollment. Moreover the deterrent effect of CMS’s enforcement efforts will be greatly enhanced if plans know that publicity will ensue. Currently plans facing even severe sanctions face few public consequences.

### **Integrated Dual-Eligible Special Needs Plans (p. 110)**

The draft Call Letter asked for comment on areas, other than supplemental benefits, where administrative flexibility could promote alignment, looking particularly at beneficiary communications, coordination of regulatory oversight and integration of state quality-of-care priorities. We believe that there is much room for innovation in these areas, including:

- **Language access:** A particular concern is communications in languages other than English. Many D-SNP beneficiaries receive a wide range of notices in their preferred language for their Medicaid benefit because the state Medicaid agency requires it. Yet on the Medicare side, these same individuals often receive notices in English without even a multi-lingual insert because Medicare rules are much more limited. To the extent that administrative flexibility is needed to allow more translated materials, we fully support such flexibility. Moreover, we believe that D-SNP plans should be required to comply with Medicare or Medicaid language access rules, whichever are more favorable to the beneficiary, so that beneficiaries receive consistent notifications in one language.
- **Tailored notices:** We strongly support more tailored notices and flexibility to allow plans to deviate from the standard Medicare form notices. Tailored notices can be clearer about the integrated benefit and can eliminate portions of the standard notices that are irrelevant to dual eligibles and can better reflect the Medicare/Medicaid relationship within a particular state.
- **Consumer testing:** Plans should be allowed and encouraged to conduct consumer test notices. We also have seen that notices developed with stakeholder participation are much stronger. Such participation should be routine in notice development.

### **Seamless Conversion Enrollment Option (p. 111)**

We ask that CMS consider carefully whether the seamless enrollment option for D-SNPs is an appropriate way to address beneficiary needs and protect beneficiary rights. We urge extreme caution in expanding this option.

We recognize that transition into a D-SNP operated by the same plan sponsor that provides a beneficiary's Medicaid services may be a reasonable choice for many beneficiaries. But, as CMS has noted in its February 10 memorandum to Medicare-Medicaid plans and in this draft Call Letter, section 70.6 of the Medicare Marketing Guidelines allows sponsoring organization to contact current Medicaid managed care members to promote Medicare products from the same sponsors. This provision gives sponsors of Medicaid managed care plans an open opportunity to contact their members to discuss the benefits of transitioning into its D-SNP. The leeway given plans in section 70.6 gives plan sponsors more than ample opportunity to make their case to any particular Medicaid beneficiary transitioning into Medicare and to give the beneficiary guidance on how to sign up.

We have serious concerns about the further step currently endorsed by CMS, "seamless"—which equates to passive--enrollment into a D-SNP operated by the same plan sponsor. Seamless enrollment

into a D-SNP may not be the best or preferred choice for a significant number of beneficiaries. Beneficiaries may need access to providers outside of the plan network or the D-SNP's formulary may not meet the needs of the beneficiary.

Passive enrollment compromises the guarantee of freedom of choice for Medicare beneficiaries. It is a particular concern when passive enrollment is imposed specifically on people with low incomes, while most other Medicare beneficiaries never encounter the issue. Further, the experience of the dual eligible demonstrations to date has shown that passive enrollment notices are, by their very nature, confusing to beneficiaries and that passive enrollment engenders distrust among beneficiaries leading to high opt-out rates. All of these concerns are relevant to the seamless enrollment option as well.

If, despite our concerns, CMS continues with seamless enrollment into D-SNPs, we ask that CMS exercise caution in approving additional requests for seamless conversion and carefully review letters sent to beneficiaries to determine that they spell out options clearly, including the benefits of traditional Medicare. Further there should be a clear encouragement for the beneficiary to contact the state SHIP agency for assistance.

### **Benefit Flexibility for Highly Integrated, High Performing Plans (p. 112)**

We endorse careful experimentation in this area. We do have concerns, however, that the definition of a "high performing plan" in section 40.4.4 of Chapter 16b of the Medicare Managed Care Manual is a plan in a contract with at least three stars. We do not believe that a three-star plan, which is merely adequate, should be treated as high performing. The option should only be available to plans with a four star or higher rating. We also ask that, for plans given flexibility to offer supplemental services, CMS carefully monitor how often such services are actually delivered, which services are delivered and under what circumstances. We are particularly concerned about plans that supposedly "offer" enhanced benefits to dually eligible beneficiaries where accessing these benefits proves difficult or impossible. We also ask that CMS make data publicly available about the delivery of supplemental services.

### **Value Based Contracting (p. 113)**

CMS expresses its intent to begin a dialogue with Medicare Advantage organizations and health care providers with respect to incentive payments, innovative payment designs and value-based contracting.

We commend the careful process reflected in the draft 2016 Call Letter, focused on transparent information gathering and the involvement of multiple stakeholders. We urge CMS to include beneficiaries and consumer advocates in these conversations, specifically to assess needed messaging, education and tools to help beneficiaries maximize a continuously evolving Medicare delivery system.

### **Tiered Cost-Sharing of Medical Benefits (p. 128)**

We have strong reservations about tiered cost sharing for medical benefits and ask CMS to monitor closely both plan performance and beneficiary experience in plans that employ this approach. One concern is whether and how CMS can effectively monitor whether plans are designating a provider as preferred based on "efficiency and quality data" and not just based on lowest price. We also are concerned about how preferred and non-preferred suppliers are presented in provider directories and on the Medicare Plan Finder. Geographic availability of preferred providers, particularly in rural areas is

another major concern, as is the availability of preferred providers who serve primarily lower-income or limited English proficient beneficiaries.

More generally, plan design with both a preferred provider network and a preferred pharmacy network creates layers of complexity that make reasoned consumer choice among plans increasingly difficult. The complexity similarly hinders the ability of a beneficiary to navigate plan benefits once enrolled. We have questions, for example, about the criteria for allowing a beneficiary to use a non-preferred provider at preferred provider co-pay rates, the process for requests, and how that information is transmitted to plan members.

We also want to highlight here another emerging issue in plan design that, like preferred providers, raises concerns about whether beneficiaries can have full access to a plan provider network and about the transparency of provider directories. The issue is delegation by plans of responsibility-- and sometimes risk-- to provider groups, care coordination entities and other entities. This can lead to situations where the delegated entity, either in practice or explicitly, limits an enrollee's choice of network providers to those providers within the delegatee's sub network. We are seeing significant delegation in dual eligible demonstrations and understand that it may be a technique used by other Medicare Advantage plans as well. We ask CMS to carefully monitor plan delegation and its effect on network access. We also ask for specific direction telling plans that they may not use delegation to in any way limit beneficiary access to all network providers.

#### **Guidance to Verify that Networks are Adequate and Provider Directories are Current (p. 134)**

We are strongly supportive of CMS's proposals in this section. Advocates report that beneficiary frustration with out-of-date provider directories is a major and continuing concern. We hope that CMS will consider releasing data from its contractor monitoring so that all stakeholders have a better picture of the major issues and of what progress is being made.

In addition, we strongly support CMS's proposal to institute a requirement for plans to provide, and regularly update, network information in a standardized, electronic format for eventual inclusion in a nationwide provider database. The Medicare Advantage program is designed around a market model and market models can only work if consumers can easily access the information that they need to make informed choices.

We hope that standardization would allow provider searches through the Plan Finder. We also believe that a uniform system that is consistent with one used by Marketplace plans will be extremely helpful as beneficiaries transition from Marketplace coverage to Medicare. We ask that CMS also include state Medicaid agencies in the planning and design and to strongly encourage full Medicaid participation so that state systems could also be ready to participate. This would be extremely helpful for the many beneficiaries who will over time be transitioning from expansion Medicaid into Medicare.

We also note that, while we strongly support CMS's proposal concerning provider network directories, we are deeply disappointed that CMS has taken no further action, either in the draft Call Letter or in the recently released final C & D rule for 2016, to strengthen consumer protections surrounding mid-year provider network terminations. The most effective way to protect consumers from being trapped in their plans after their own doctors are involuntarily terminated is to prohibit plans from terminating network providers mid-year without cause. Not only did CMS retreat from this option in the final 2015

Call Letter, but there has been no attempt to extend the current 30 day advance notice to affected beneficiaries, as suggested in last year's draft Call Letter.

Further, CMS has failed to strengthen or otherwise expand the limited special enrollment period (SEP) right available only to beneficiaries affected by "significant" network terminations. Even if a beneficiary loses all of his providers mid-year, the SEP is not available unless the change to the network as a whole lost "significant." This is of little comfort to beneficiaries who are experiencing drastic and unexpected changes in provider access. Having more accurate provider directories during the annual enrollment period, while a welcome improvement in consumer information, is not a cure for this serious problem.

#### **Standardizing the Health Risk Assessment and Guidance for In-Home Enrollee Risk Assessments (p. 138)**

We support CMS's effort to look more carefully at-home risk assessments, which can be a valuable tool -if used appropriately --and can be a key element in coordinated care. We share CMS's concern that the at-home risk assessment is not being appropriately applied. We support best practices and more consistency in components of HRAs but believe one of the most important ways to address the issue is to look at the alignment or misalignment of delivery of services with HRA findings. We urge CMS to develop that data even as it works toward more uniform assessment tools.

#### **Drug utilization review (p. 142)**

We appreciate CMS's efforts to address the challenge of opioid misuse in a responsible and restrained way, including requirements related to the involvement of treating physicians and common-sense exceptions to ensure limited impact on beneficiaries with a medical necessity for specific medications. We encourage CMS to continue to approach this issue carefully and to ensure adequate beneficiary protections are implemented as part of any expansion in the use of additional pharmacy edits.

Before CMS considers expanding current policy to additional categories, we urge CMS to further study the experience with opioids. We believe that additional beneficiary protections must be put in place to ensure that Medicare beneficiaries are not unduly prevented from receiving necessary care. We continue to be concerned with the implementation of any additional point-of-sale edits or restrictions, as our experience and CMS's own audit results show that these restrictions are routinely mismanaged by plans and pharmacy benefit managers.

We encourage CMS to continue to work with all stakeholders, including physicians who specialize in treating addiction, to develop effective and targeted strategies. The goal in all cases must be the best drug treatment regime for the individual beneficiary and, when needed, safe and appropriate transitions consistent with best medical practice.

#### **Tier Labeling and Composition (p. 151)**

Starting in 2016, CMS proposes to alter nomenclature for generic tiers. We support this change as it will be clearer and easier for beneficiaries to understand. We also strongly support the increased scrutiny of formulary design reflected in the draft Call Letter. In particular, we encourage CMS to review plan placement of first-line, clinically-preferred generics on higher tiers.

We are more broadly concerned that formulary robustness and affordability are declining. Of particular concern is the shrinking of formularies in benchmark plans. Advocates report that they increasingly need to advise LIS beneficiaries that they should enroll in plans above benchmark because those are the only plans that meet their needs. These experiences are consistent with findings by Avalere Health that both the total percent of drugs and the percent of brand name drugs in benchmark plans have declined consistently over the last three years.

We are also concerned about the growing frequency with which plans utilize co-insurance percentage, rather than copay amounts as reflected in a recent data analysis by Avalere Health.<sup>1</sup> Because non-specialty tiers can employ coinsurance rates as high as 50 percent, this can represent a significant increase in cost sharing to beneficiaries and less predictability about annual medication costs.

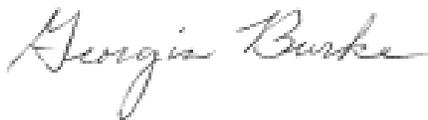
### **Specialty Tiers (p. 154)**

We appreciate that CMS has made it very clear to plans that they may not exempt payments for any tiers from counting toward a beneficiary's deductible. We ask CMS to continue its vigilance and refuse to allow any further plan "innovations" that increase complexity and negatively affect transparency for beneficiaries. Plan design has grown dramatically more complex since the introduction of Part D in 2006 and the complexity has not served beneficiaries well.

We continue to urge CMS to increase the \$600 threshold for specialty tier medications, a threshold that has not been adjusted since the start of the program. We also reiterate the request that advocates have made for many years that CMS allow tiering exceptions for prescription drugs placed on the specialty tier, both as a matter of fairness and to promote affordable access to high-cost, highly effective medications. The lack of access to a tiering exception particularly impacts beneficiaries living on low, fixed incomes not low enough to qualify for the Low Income Subsidy.

Thank you for the opportunity to submit these comments.

Sincerely,



Georgia Burke  
Directing Attorney

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<sup>1</sup> Avalere Health. "Avalere Analysis: Medicare Beneficiaries Will Pay Higher Out-Of-Pocket Costs As PDPs Increase Use Of Coinsurance In 2015." November 13, 2014. <http://avalere.com/expertise/life-sciences/insights/avalere-analysis-medicare-beneficiaries-will-pay-higher-out-of-pocket-costs>