

# JUSTICE IN AGING

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December 31, 2018

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Centers for Medicare & Medicaid Services  
Department of Health and Human Services,  
Attention: CMS-4185-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

**Re: CMS-4185-P Medicare and Medicaid Programs: Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021.**

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Notice of Proposed Rulemaking (NPRM).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use 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 and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

We appreciate the opportunity to comment on the changes proposed in this rulemaking. Our comments are keyed to the headings in the NPRM and are presented in the order discussed there.

## **II.A.1. Requirements for Medicare Advantage Plans Offering Additional Telehealth Benefits (§§ 422.100, 422.135, 422.252, 422.254, and 422.264)(NPRM at 54987)**

We appreciate the potential and the complexities of telehealth, particularly because it is a rapidly developing field. Telehealth can be particularly beneficial for frail older adults and persons with disabilities for whom travel to a provider can create difficulties. We also note that beneficiaries who rely on non-emergency medical transportation (NEMT) for provider appointments, either through Medicaid or as a supplemental Medicare benefit, report continuing inadequacies in delivery of that benefit. To the extent that telehealth can relieve some of those burdens for Medicare Advantage enrollees without diminishing the quality of care, we support broadening of telehealth Part A or Part B benefits that would not be covered by Original Medicare. We also support the broadening of telehealth options for supplemental benefits, such as supplemental dental benefits.

Parity for Original Medicare: We are concerned however that broadening of the basic benefit coverage, though a positive for Medicare Advantage enrollees, comparatively disadvantages beneficiaries receiving Medicare through fee-for-service. We urge that, if the agency believes that the geographic

### WASHINGTON

1444 Eye Street, NW, Suite 1100  
Washington, DC 20005  
202-289-6976

### LOS ANGELES

3660 Wilshire Boulevard, Suite 718  
Los Angeles, CA 90010  
213-639-0930

### OAKLAND

1330 Broadway, Suite 525  
Oakland, CA 94612  
510-663-1055

and patient setting requirements in the current law are overly restrictive and out of date in light of developments in telehealth, CMS should work with the Congress to remove restrictions so all beneficiaries can have access to similar telehealth options.

Of particular concern in fee-for-service Medicare are telehealth services for diabetes. Despite the breadth of evidence supporting the efficacy of offering the diabetes prevention program (DPP) online, CMS has declined to at least test coverage for this service, after indicating plans to test virtual DPP in 2017. Similarly, we encourage CMS to at least test coverage of online diabetes self-management training (DSMT) programs. As CMS itself highlighted in 2016, DSMT is an underutilized Medicare benefit that has great potential for cost savings and improved health outcomes for beneficiaries with diabetes.<sup>1</sup> Allowing coverage of online DSMT would remove a large barrier to access.

QMB protections: We request that CMS clarify that Qualified Medicare Beneficiary (QMB) billing protections in Medicare Advantage apply to all Part A and Part B services delivered through telehealth, including those that, because of restrictions in the statute would not be covered in fee-for-service. Without this protection, a QMB in Medicare Advantage would face the anomalous situation of having payment protection for an in-patient visit but being charged for telehealth delivery of the same service.

Protecting beneficiary choice: Preserving beneficiary choice in how to receive services is an important element in patient-centered care. We support CMS's proposed requirement that beneficiaries have the right to choose care either through telehealth or in-person. Ensuring that beneficiaries have the maximum choice in deciding how to access their care requires attention to inequalities in access to the internet and to computer equipment and smartphones.<sup>2</sup> Plans have options to address these issues such as providing phones or tablets to beneficiaries as was done by some plans in the dual eligible financial alignment demonstrations, conducting telehealth through devices brought by home health workers, making internet connections available at locations convenient to beneficiaries, etc. We ask that CMS require plans to demonstrate how they intend to address these inequalities so that telehealth benefits are available to all their members. Further, CMS should monitor the extent to which plans implement what they promise.

It is equally important that beneficiaries who want to access care through face-to-face encounters are not disadvantaged. We ask that CMS closely monitor the differential co-insurance amounts for telehealth versus face-to-face to ensure that they fairly reflect actual cost differentials and are not used to steer beneficiaries away from their preferred methods of care.

Differential rates also should not penalize those beneficiaries who cannot afford telehealth access or who, because of disabilities, cannot use telehealth services. Plans that do not provide these individuals with the assistance they need to access telehealth services, as discussed above, should not be permitted to charge them higher differential rates.

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<sup>1</sup> [www.govinfo.gov/content/pkg/FR-2016-07-15/pdf/2016-16097.pdf](http://www.govinfo.gov/content/pkg/FR-2016-07-15/pdf/2016-16097.pdf)

<sup>2</sup> Many low-income beneficiaries lack access to broadband and other technologies. For example, only 27% of older adults earning \$30,000 per year or less have broadband, compared to 87% of older adults earning \$75,000 or more. Only 27% of older adults earning less than \$30,000 per year, and 32% of those earning between \$30,000-\$50,000 have a smartphone. See 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](http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf).

In-network providers: The NPRM asks for comments on its proposed limitation to in-network providers for its extension of telehealth basic benefits. We caution against a blanket limitation. For HMOs, we could see situations where a plan member has a unique or rare issue and consultation with an out-of-network provider, perhaps across the country, would be useful. We realize that in most cases those consultations are provider-to-provider but there can be instances where a tele-examination or other direct contact with the beneficiary would be the most appropriate action. For PPOs, we believe the expanded coverage of telehealth should extend beyond in-network providers. Individuals who chose a PPO do so because they want access to a wider range of providers and their expectation is that they can do so in whatever ways other patients of those providers can do so. We recognize the issue of oversight raised in the NPRM, specifically that plans do not have the same oversight of out-of-network providers that they have of providers that are under contract, but that issue exists whether or not telehealth is involved.

We also are concerned about the ability of plans to communicate the in-network limitations clearly to beneficiaries. Explaining that the plan will cover telehealth from an out-of-network provider for some Part A and B services (those for which telehealth is covered in fee-for-service) but not for other Part A and B services and explaining the difference seems to us an impossible task. Beneficiaries choosing among plans and, after enrollment, deciding to access services, need a framework that makes sense and is easy to navigate.

Telehealth and Network Adequacy: The NPRM suggests that adding telehealth benefits could allow an adjustment to network adequacy requirements by factoring in telehealth providers in the evaluation of network adequacy. We encourage CMS to continue basing the network adequacy requirement only on in-person services. Given the disparity in access to broadband, it is crucial that CMS continue to require Medicare Advantage plans to offer appropriate coverage of providers for in-person Part B services, regardless of their telehealth offerings. Minimally, CMS should wait to evaluate this possibility until there is a higher market saturation of telehealth providers for Part B services.

## **II.A.2. Dual Eligible Special Needs Plans**

- a. Integration Requirements for Dual Eligible Special Needs Plans (§§ 422.3, 422.60, 422.102, 422.107, 422.111, and 422.752)(NPRM at 54992)

Context: Justice in Aging has observed D-SNPs since their inception, commented on different iterations of D-SNP regulations and guidance, and provided assistance to advocates working with beneficiaries enrolled in D-SNPs. From the beginning, we have seen that D-SNPs have offered promise for beneficiaries needing to navigate their Medicare and Medicaid benefits. The actual performance of D-SNPs however has been mixed, with many offering little more than any other Medicare Advantage plan. As discussed in the NPRM, over time CMS and states have imposed more specific requirements on D-SNPs, which has brought some improvements, particularly where states have required strong contractual commitments.

An unfortunate recent development has been the emergence and growth in D-SNP “look-alikes,” Medicare Advantage plans that are designed to attract dual eligibles but are not subject to any of the D-SNP contracting or reporting requirements. It appears that some plan sponsors find the look-alikes more profitable because they can draw payment based on dual status and levels of acuity but are not subject to state contractual requirements or the additional performance and reporting requirements of

D-SNPs. These plans are a step backwards from coordination and integration of care and we believe it is important that CMS take steps to rein them in.

We recognize that addressing the challenge of D-SNP look-alikes may be beyond the scope of this rulemaking. We have concerns, however, that some health plan sponsors may suggest that the proper response to look-alike plans is for CMS to lower standards and requirements for D-SNPs, arguing that they impose too many costs or administrative burdens. That response is the wrong answer to the challenge of D-SNP look-alikes and contrary to the statutory mandate of the Bipartisan Budget Act of 2018 (the “Act”) which clearly directs CMS to strengthen D-SNP requirements in order to make them more robust products to serve the needs of dual eligible individuals.<sup>3</sup> We appreciate that CMS has taken steps in their proposed regulations to respond to that mandate and urge additional steps to fully implement statutory intent.

(1) Definitions of a “Dual Eligible Special Needs Plan”, “Fully Integrated Dual Eligible Special Needs Plan”, “Highly Integrated Dual Eligible Special Needs Plan”, and “Aligned Enrollment” (§ 422.2)

Dual Eligible Special Needs Plan: We believe that the broad definition of what D-SNPs do, that is, “provide, as applicable and coordinate” Medicaid services, is appropriate as long as there is subregulatory guidance that spells out more clearly the minimum requirements for coordination. As the NPRM notes, merely giving a plan member a phone number to call is far from adequate. D-SNPs should be held accountable for actively coordinating benefits and linking plan members with services, both when those services are provided by the D-SNP or its affiliate and when they are provided by an unaffiliated third party.

We do, however, ask CMS to revisit its analysis rejecting inclusion of a requirement that, in a state with Medicaid managed care, a D-SNP must have a contract with the state to offer a companion Medicaid managed care plan.<sup>4</sup> We support such a requirement because, without it, a beneficiary in a non-aligned D-SNP has no option other than enrolling in a Medicaid managed care plan operated by another sponsor (or, if permitted, receiving fee-for-service Medicaid services), significantly reducing the opportunity for care coordination.

There also are more subtle concerns. A plan sponsor with a Medicaid managed care contract will understand the state’s Medicaid program and its nuances in a way that a sponsor without a contract simply cannot. Thus, even when D-SNP enrollees choose not to join an aligned Medicaid plan, a D-SNP with a Medicaid contract is better positioned to assist with navigating Medicaid benefits. We also suggest that CMS look into the extent to which D-SNPs without Medicaid contracts have enrollments that are primarily partial dual eligible beneficiaries for whom there is no need or opportunity to coordinate Medicaid benefits. As discussed further at p. 7 below, we are very skeptical about the value of such plans. Not requiring a companion Medicaid plan seems to open the door to plans that, though they purport to be D-SNPs, are not targeting those dual eligible beneficiaries who need coordination of benefits, an essential element of the D-SNP model.

Having raised these concerns, we also recognize that there may be practical issues in imposing such Medicaid contractual requirement. They include coordination in application and award timetables for Medicare and Medicaid contracts. We also note that some plan sponsors that have been very active in

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<sup>3</sup> Bipartisan Budget Act of 2018, (Pub. L. 115-123), (“BBA”), § 50311(b).

<sup>44</sup> NPRM at 54995.

Medicaid managed care have limited experience with D-SNPs and some major D-SNP plan sponsors have limited experience with Medicaid contracts. Thus, it may be prudent in some states to phase in a requirement, but we believe it is important that the requirement be there.

In addition, as a partial response to the challenge of look-alike plans, we also ask CMS to consider expanding the D-SNP definition to state that any Medicare Advantage plan with a dual eligible membership of 50% must meet all the regulations affecting D-SNPs, including the requirement to enter into a contract with the state, in order to continue operating.

If a plan sponsor creates a product to serve dual eligible beneficiaries, that product should be submitted for review as a D-SNP. The sponsor should be required to seek a state contract like any other D-SNP. We urge CMS at the front end to scrutinize annual plan submissions, looking at the design of plan benefits and cost-sharing, to determine if a plan is targeting dual eligible beneficiaries. Our proposed provision would be a back end protection to supplement the initial review process.

HIDE SNPs: We believe that the proposed definition of HIDE SNPs is appropriate. State carve-outs, although conceptually a barrier to integration, are in some cases well-established and provide quality services. Though longer term integration is a goal, hurried dismantling of those systems would be unwise and could cause beneficiary harm. The HIDE SNP definition recognizes this reality. We urge CMS, however, to work with states that have carve-outs to ensure that, on the state side, there is a commitment to coordinate carved-out services with D-SNPs. That commitment needs to be backed up with specific procedures and protocols. We have seen that need, for example, in Cal MediConnect, the California dual eligible financial alignment demonstration. There care coordinators from In-home Supportive Services (IHSS), a carved-out service, had been participating in care coordination meetings with plans. Then IHSS policies shifted and the state no longer paid for IHSS staff participation. When those payments stopped, IHSS care coordinator participation in meetings, not surprisingly, dropped off precipitously. Coordination requires a commitment on both the Medicare and Medicaid side.

Exclusively aligned enrollment: Although the proposed definition of exclusively aligned enrollment can be helpful in categorizing D-SNPs, we do not believe that the integration of appeals at the plan level should be limited to those D-SNPs with exclusively aligned enrollment. (See fuller discussion at p. 10 below.) The mere fact that a FIDE SNP or HIDE SNP has some members who are not enrolled in an aligned Medicaid managed care plan should not preclude integrated appeals for those members who have aligned coverage.

## (2) Dual Eligible Special Needs Plans and Contracts with States (§ 422.107)(NPRM at 54996)

Notice of hospital or SNF admission. Transitions from hospital or skilled nursing facilities are times where care coordination is most critical and, for dual eligible individuals, care coordination frequently requires coordination with Medicaid-funded services. As the NPRM notes, the notification requirement in the Act is only one facet of a successful care transition, but a very important one.<sup>5</sup>

Looking at the specific proposed regulation, we recognize that some flexibility and experimentation may be needed in implementing the notification requirement of the Act and that there may be value in starting with specific subsets of beneficiaries. We ask, however, that CMS make very clear to plans that they must protect all their enrollees during care transitions and that a state's decision to focus in on a

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<sup>5</sup> NPRM at 54996.

particular subset of beneficiaries for purposes of the reporting required by the Act does not relieve them of the obligation to coordinate transitions for all their other enrollees.

We also ask that the regulation explicitly state that the narrow subset notice requirements are a transition step to full implementation of the directive of the Act. Section 50311 (b) of the Act clearly envisions a more comprehensive notice requirement for D-SNPs that encompasses all plan members. The NPRM recognizes this in part by asserting that the proposed regulation is meant to give states flexibility to begin on a path toward greater integration and envisions that states may choose to scale up requirements after testing approaches.<sup>6</sup> We believe that the Act not only permits scaling up but requires it. To facilitate full implementation, we ask that CMS establish timelines and benchmarks for states and plans as they test notification systems and approaches.

We also ask that, for purposes of the currently proposed limited requirements, the agency revisit its decision not to impose a specific minimum timeframe, such as 48 hours, on reporting.<sup>7</sup> Definite time requirements are clearer for plans to implement and easier for regulators to monitor. A 48 hour requirement is reasonable and synchronizes well with the requirements for discharge notices. The need for prompt notice is consistent across states and settings. States could have the option of imposing more stringent requirements but this is one area where uniform minimums are appropriate.

Proposed § 422.107(d) imposes the notice requirement only on D-SNPs that are not FIDE SNPs or HIDE SNPs. We ask that CMS, to be consistent with the purposes of the Act, extend those notice requirements to FIDE SNPs and HIDE SNPs when the affected member is not receiving Medicaid services through the SNP. Placing a notice obligation on these SNPs for those members during care transitions would serve the same important purpose as a notice requirement for D-SNPs that are aligned. For example, if a HIDE SNP operates in a state where LTSS is carved out from Medicaid managed care, such notice could be critical to a safe transition from a hospital or SNF. Similarly a hospitalization of an individual using carved-out behavioral services would be as important for coordination of services, particularly if the hospitalization was for a behavioral health emergency. For these reasons, we urge CMS to extend these notice requirements to all situations where a D-SNP is not itself responsible for all of the affected beneficiary's Medicaid services, including situations where the SNP is a FIDE SNP or a HIDE SNP.

Additional Requirements: CMS asked for comments on whether the agency should be more prescriptive and include additional requirements for D-SNPs. We believe that additional requirements would be helpful for plans and beneficiaries. We support especially two proposals that CMS identified as ones that the agency considered and rejected: a requirement for coordination of assessments and a requirement for training of staff and network providers.<sup>8</sup>

We urge a requirement for coordination of Medicare and Medicaid assessments, though believe it appropriate to leave the details to subregulatory guidance and state contracts. We can report instances where the current situation is extremely unwieldy. For example, in Los Angeles County there are five Medicaid plans with five different sets of health risk assessment questions for Medicaid-covered services. If there were multiple D-SNPs, they might also each have their own assessment questions. Assessments are lengthy documents completed on the phone or sent through the mail. Conducting them at the same time and/or coordinating questions not only is less burdensome for all but also

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<sup>6</sup> NPRM at 54996.

<sup>7</sup> NPRM at 54997.

<sup>8</sup> NPRM at 54997.



increases the likelihood of the assessments being completed. Placing that responsibility on the D-SNP appears to us to make the most sense since the D-SNP has primary clinical responsibility.

We also urge a requirement for training of staff and network providers on the availability of LTSS and behavioral health services and on other topics as determined by CMS and state contracts. Identifying training as an explicit requirement in the regulations gives CMS and the states the ability to use subregulatory guidance and contracts to ensure minimum standards and set training requirements that respond to identified gaps in D-SNP performance. Further, having a regulation requiring training of network providers, not just staff, gives plans a tool to ensure provider cooperation. We ask that the training requirement be stated broadly to include more than just knowledge of Medicaid programs so that CMS and the states have the flexibility to require training on some of the many other issues that disproportionately affect dual eligibles: disability and access issues, language access and cultural competency, LGBT issues, etc. Now that D-SNPs are permanently authorized, it is reasonable to expect that their memberships and provider networks will grow and the need for training will grow as well.

Documenting categories of beneficiaries eligible to enroll: We appreciate and support proposed § 422.107(c)(2) providing for documentation of both D-SNP eligibility categories and additional criteria of eligibility, e.g., limiting enrollment to beneficiaries requiring a nursing home level of care, or requiring enrollees to enroll in a companion Medicaid plan in contracts between states and plans. The requirement provides clarity and increases transparency.

Documenting Medicaid services for which the D-SNP or affiliates is responsible: We also appreciate and support proposed § 422.107(c)(3), which would also provide clarity and transparency with respect to the Medicaid services for which the D-SNP is responsible. We further appreciate that CMS reiterated that plans have the obligation to understand all services in a state's Medicaid program and to be able to assist enrollees in accessing those services, including those for which the plan and affiliates are not directly responsible.

(4) Eligibility of Partial-Benefit Dual Eligible Individuals for Dual Eligible Special Needs Plans (NPRM at 54999)

We share the agency's concern about whether D-SNPs offer value to partial benefit dual eligible individuals (partial duals). These beneficiaries are only enrolled in Medicare Savings Programs and do not receive full Medicaid benefits.

As the NPRM notes, one concern is simplification of communications. This concern extends not only to evidence of coverage and other core marketing documents, but also to marketing presentations by agents and brokers and one-on-one sales pitches. The potential for partial duals to believe that plan membership will provide access to Medicaid benefits for which they otherwise would not be eligible is high.

Partial duals also would not be able to use an integrated appeals system and the differences in appeal rights would need to be explained, further complicating the communications challenges.

Our broader concerns, however, are about the value that current D-SNPs add for partial duals. Advocates report to us that, as a general matter, they have seen little benefit to partial duals. We also have heard comments that many partial dual D-SNP members do not even know that they are in a D-SNP. Some advocates have speculated that D-SNP membership may have reduced somewhat the

potential for improper billing. However, with the advances that CMS has made with all Medicare Advantage plans in developing plan awareness of their responsibilities to shield their members from improper billing, we expect that this possible advantage has diminished.

D-SNPs whose memberships are primarily but not entirely composed of partial duals are particularly problematic. Because of low full-benefit dual membership, such plan may not invest in the infrastructure, personnel and planning to offer its full benefit dual eligible members the services expected. States may devote few of their resources to coordination with or oversight of D-SNPs if the majority of the D-SNP's members are partial duals. As it reviews policy options, we urge CMS to look particularly at the experience of states where there is a concentration of D-SNPs with majority partial dual enrollment.

We have concerns that significant partial dual membership may offer opportunities for plans to game quality measures and star ratings. There may be opportunities to mask poor performance in coordination with Medicaid or to overstate coordination performance because a plan has a smaller numbers of full benefit duals compared to total enrollment.

In considering the issue of partial dual membership, we urge CMS to look especially at how these issues have played out in currently operating D-SNPs with large partial dual membership.

We recognize that there are some enrollment issues for partial duals that enrollment in a D-SNP purports to address. For example, beneficiaries lose Medicaid eligibility, often for only a short period of time (churning), or beneficiaries with spenddown/share of cost meet their share of costs intermittently. There are better and simpler answers to the issues, including expanding policies around Medicaid authorization, eligibility periods, etc. Those policy improvements more directly address the issues and do not come with the same disadvantages and concerns that partial dual D-SNP enrollment presents.

In light of all these considerations, we urge CMS not to permit blanket enrollment of partial duals in D-SNPs. We ask that CMS consider either entirely prohibiting partial dual enrollment or limiting it significantly. In any situation where the agency does permit partial dual enrollment, the D-SNP should be required to set out specifically how it will meet the needs of its partial dual members in a way that is distinct from the benefits that a non-D-SNP Medicare Advantage plan would offer. Further those special benefits should be measurable and subject to evaluation and oversight. Because the core mission of D-SNPs is coordination of Medicare and Medicaid benefits, we also ask that CMS place marketing restrictions on D-SNPs so they cannot primarily target partial duals and that CMS carefully monitor enrollment patterns.

(5) Suspension of Enrollment for Non-Compliance With D-SNP Integration Standards (§ 422.752)(NPRM at 54999)

We support the proposed regulation to allow CMS to impose an intermediate sanction for plans that fail to comply with one or more of the integration requirements. It has been our experience that an intermediate sanction can be less disruptive for plan members than an immediate termination, as long as CMS retains authority to impose immediate termination when any immediate harm to enrollees is imminent. We also believe, as a practical matter, having the full range of options available makes it easier for CMS to exercise its enforcement authority. We urge CMS to evaluate this sanction to determine the best course of action after 2025.



**b. Unified Grievance and Appeals Procedures for Dual Eligible Special Needs Plans and Medicaid Managed Care Plans at the Plan Level (§§ 422.560-562, 422.566, 422.620-634, 438.210, 438.400, and 438.402)( NPRM at 54999)**

(1) Assisting With Medicaid Coverage Issues and Grievances (§ 422.562(a)(5))(NPRM at 55001)

We appreciate and support the requirement that all D-SNPs, not just those that are aligned, offer assistance with Medicaid appeals. We appreciate the examples provided in the proposed regulations. We propose adding that the D-SNP “provide all such assistance in a language and format needed to effectively assist the enrollee and in compliance with all language and disability access provisions in these regulations and in the state contract.”

We also have questions about the accountability process. Section 422.562(a)(iv) provides that the plan must, upon request from CMS, provide documentation demonstrating its compliance with these requirements. We appreciate this requirement but are unclear about the mechanism whereby CMS will oversee compliance. For example, will review be incorporated into the audit process? Will there be annual reporting? In either case, will monetary penalties attach to noncompliance? Will it affect star ratings? It is important for plans, beneficiaries and other stakeholders to have a clear understanding of oversight and enforcement mechanisms for this and other requirements in this NPRM to ensure both transparency and accountability.

We propose to add to § 422.562(a)(v), the following sentence: “The dual eligible special needs plan, whether or not the enrollee accepts the plan’s offer of assistance, also must make available to an enrollee specific contact information for organizations providing free legal services that could provide legal assistance with an appeal and for any applicable ombudsman programs.” To offer these resources, plans would necessarily need to have knowledge of local legal aid programs and the ombudsman networks and maintain up-to-date contact information. To increase accuracy, state contracts could require that all D-SNPs in an area share information and provide a single up-to-date list to affected members.

We believe this addition is essential. Enrollees may not trust the D-SNP to assist with an appeal, particularly when the appeal is with an aligned Medicaid plan. Further, some appeals may benefit from a level of legal assistance that the D-SNPs simply cannot offer. In all cases, it is important that D-SNPs educate their enrollees on the full range of resources available to assist with their appeal.

In addition to assistance with appeals of Medicaid denials of coverage, we recommend that plans also be required to assist with Medicaid eligibility. A persistent problem both in Medicaid generally and in the financial alignment demonstrations has been individuals falling off Medicaid eligibility, often because they did not understand the redetermination process or have difficulties in providing needed information. Financial alignment demonstration plans have experienced some success in helping enrollees to stay enrolled in Medicaid or to remedy paperwork problems that led to disenrollment. MMCO also noted in its recent State Medicaid Director Letter that Florida requires such assistance by its D-SNPs.<sup>9</sup> Eligibility assistance aligns with the plans’ interest since an individual who no longer qualifies for dual eligibility cannot continue plan membership. It is our experience that the need for such assistance extends across all states and so we urge that this requirement extend to all D-SNP contracts.

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<sup>9</sup> SMDL #18-012, Ten Opportunities to Better Serve Individuals Dually Eligible for Medicare and Medicaid (Dec. 19, 2018), available at [www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf](http://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf).

The support should be available to all members and should help with all aspects of an eligibility problem, be it a need to reapply, respond to a redetermination, appeal a denial, etc.

(3) Definitions of “Applicable Integrated Plan”, “Integrated Appeal”, “Integrated Grievance”, “Integrated Organization Determination”, and Integrated Reconsideration,” and General Requirements for Applicable Integrated Plans (§§ 422.561 and 422.629)(NPRM at 55003)

Applicable Integrated Plan: We support the overall approach of CMS that would fully integrate appeals at the plan level for FIDE and HIDE SNPs.

We disagree, however, with the proposal that integrated appeals at the plan level be required only for exclusively aligned FIDE SNPs and HIDE SNPs. We urge that CMS, instead, revise its definition of “Applicable Integrated Plan” to include all FIDE-SNPs and HIDE SNPs. For those FIDE SNPs and HIDE SNPs that do not have exclusively aligned enrollment, the requirement for plan-level integration would be limited to those enrollees enrolled in an aligned Medicaid product. We see no barriers and no excessive burden for plans to integrate appeals and grievances for their members in aligned products. Once systems are set up, integrated communications and procedures for appeals should, in fact, ease administrative complexity for plans. From the beneficiary point of view, integrated appeals can be an important benefit of enrollment in an aligned product and that benefit should not be conditioned on how a state decides to limit membership.

The situation under the currently proposed definitions is particularly unfair with respect to the protections attached to the proposed integrated appeals process. For example, Beneficiary A and Beneficiary B are each enrolled in a HIDE SNP and each receives Medicare and Medicaid benefits from their HIDE SNP and its affiliated entities. Yet, Beneficiary A would not have the same continuity of services rights and protection from Medicaid cost recovery during an appeal (both discussed in item (7) below) as Beneficiary B, simply because Beneficiary B’s HIDE SNP is exclusively aligned while Beneficiary A’s HIDE SNP has some members, perhaps very few, who are receiving Medicaid services outside of the HIDE SNP. We do not believe that the Act contemplated such a narrow reading of its integration mandate.

We strongly urge CMS to reconsider and to extend plan-level integration to all FIDE SNPs and HIDE SNPs. If CMS, however, is unwilling to extend the requirement to all FIDE SNPs and HIDE SNPs, we ask that the agency at least encourage and permit all FIDE SNPs and HIDE SNPs that are not exclusively aligned to use integrated plan-level appeals. Plans choosing this option should be required to establish an appeals and grievance system for affected members that fully conforms to the applicable regulations and subregulatory guidance.

HIDE SNPs and Carve Outs: We recognize that complete integration may not be possible for HIDE SNPs where the service being appealed is carved out. However, we hope that states could both facilitate and require cooperation between the D-SNP and the organization or organizations providing carved out services to harmonize as much as possible their appeals communications, timing and procedures.

State Flexibilities: We strongly support proposed § 422.629(c), which allows states to implement in their contracts with D-SNPs standards for timeframes and notices that are more protective than those laid out in these regulations. This provision is particularly important because it accommodates changes over time as states strengthen beneficiary protections.

Prohibition on Punitive Actions: We strongly support proposed § 422.629(i), the provision prohibiting an applicable integrated plan from taking any punitive action against a provider for requesting an integrated organization determination or integrated reconsideration. We ask that CMS add a clarification that the integrated plan is responsible for ensuring that this prohibition is followed by contracted and delegated entities. We have concerns that, particularly when a plan's relationship with a provider or provider group involves capitation, there already are strong incentives for those entities to discourage requests for organizational determinations or redeterminations. It is important that they understand their obligation not to punish any of their providers who seek to do so.

(4) Authorization for Filing Appeals (§ 422.629(l))(NPRM at 55006)

We appreciate and support CMS's proposal to allow providers to seek an appeal without written authorization from the beneficiary. We also note that the proposal is consistent with the proposed changes to §§ 405.944(b)(4), 405.964(b)(4), 405.1112(a), and 423.2112(a)(4) included in the recent Medicare Appeals NPRM.<sup>10</sup> There are many reasons why beneficiaries, particularly dually eligible beneficiaries, may not be able to easily fulfill a signature requirement: they are too ill, they have cognitive issues, they have needs around health literacy, language, or disability or they simply are having difficulty managing their life situation and their health care needs. Advocates have not reported situations where beneficiaries have been hurt or where the Medicare program has been compromised by allowing providers to file appeals on behalf of beneficiaries. In the absence of any evidence that such a proposal would harm the Medicare program, we strongly support the CMS proposal.

We further ask CMS to reconsider its proposal not to authorize providers to request continuation of Medicare benefits without written authorization by the beneficiary. The proposed process could easily confuse both the beneficiary and the provider. We expect situations where the provider tells the beneficiary that the provider will appeal, so the beneficiary takes no action, assuming that the provider has handled everything. The provider also may not realize that only the beneficiary can request continuation of benefits. The process is difficult to communicate and navigate.

While conflict of interest may be possible if the requesting provider is also delivering the services for which continuation is sought, we question whether this theoretical concern offsets the actual difficulties that this limitation could impose on beneficiaries. The potential for abuse for D-SNP-covered services appears to us to be limited. Providers are in the plan's network so plans should be able to monitor unusual patterns with any provider that deserve scrutiny particularly because, as CMS has noted, the range of Medicare services for which continuation of benefits would apply is quite limited. Further these plans are D-SNPs and, as such, are supposed to have care coordinators and should be able, if there is an issue, to verify the wishes of the beneficiary. Moreover, the provider seeking continuation of benefits may not be providing those benefits and may instead only be prescribing services. For these reasons, we urge CMS to allow providers to request continuation of benefits for beneficiaries without written authorization just as they are permitted to appeal decisions. If abuses arise, CMS can revisit the issue.

(5) Integrated Grievances (§ 422.630)(NPRM at 55006)

We appreciate the careful analysis by CMS throughout this section on how to provide the process that is most protective for the beneficiary.

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<sup>10</sup> CMS-4174-P, 83 Fed. Reg. 49513 (Oct. 2, 2018)

Plan Responsibility for Contracted Services: In particular we endorse the proposal to hold plans responsible for resolution of grievances even if the grievance pertains to an act or decision by one of the applicable integrated plan's contracted providers or vendors. Plans increasingly are delegating responsibility for provision of services but it is very important that enrollees know that they can hold plans responsible for performance and that they have direct and simple routes to raise concerns and grievances. It also is important that plans be held to uniform application of regulations and plan policies. Beneficiary experience and rights should not depend on which delegated entity or contractor provides services. CMS and states need to ensure that all beneficiaries experience the same level of protection.

Filing Requirements: We agree that beneficiaries should be able to file a grievance at any time and that the integrated grievance process should adopt the Medicaid regulation at § 438.402 (c)(2)(i) rather than the Medicare Advantage regulation, § 422.564 (d)(a), that limits filing a grievance to within 60 days of the event at issue. Grievances provide important information to plans and their regulators about performance issues and should be addressed whenever they are filed.

#### (7) Continuation of Benefits Pending Appeal (§ 422.632)(NPRM at 55008)

We strongly support the proposal of CMS for continuation of benefits during an integrated reconsideration.

We have concerns, however, that the provision for continuation of Medicare benefits stops after plan reconsideration and does not continue through IRE review. The Medicaid process extends continuation of benefits through the first level of external review which, in Medicaid, is the fair hearing. We believe doing so with Medicare appeals would be more consistent with the Act's intent that CMS integrate processes as much as possible and would be necessary to fully comply with the Act's mandate that CMS adopt the provisions "most protective for the enrollee."<sup>11</sup>

Even if full integration of the appeals process stops at the plan reconsideration level, CMS still, within its statutory mandate, can and should take steps to achieve integration "to the extent feasible" above that level. Continuing benefits through the IRE level, which would be parallel with Medicaid requirements, would be one such step. Benefit continuation through that first level of external review is particularly appropriate and necessary to assure that low income enrollees have a meaningful path through the appeals process.

We appreciate that CMS is not proposing recoupment for continued Medicare benefits if an ultimate decision is unfavorable to the beneficiary.

We also strongly endorse the proposed prohibition of recovery of the costs of Medicaid services provided pending the integrated reconsideration and, if applicable, any state hearing. We hear frequently from advocates that they have many clients who, despite great need for a service and a strong basis for an appeal, are afraid to appeal a denial of services for fear of cost recovery. D-SNP enrollees are by definition poor, a fact that heightens that fear. As CMS notes and advocates have confirmed with us, removing recoupment from the appeals process in many of the financial alignment demonstrations worked well. Further, since dual eligibles do not have the resources to pay any

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<sup>11</sup> BBA, §50311(b)(1)(B).

recoupment, a recoupment provision leads to high levels of stress for beneficiaries without any practical possibility of significant financial benefit for D-SNPs or the Medicare program.

(8) Integrated Reconsiderations (§ 422.633)(NPRM at 55010)

We support the proposed regulations addressing integrated reconsiderations, all of which apply the most protective standard for beneficiaries. We note especially the prohibition of charging for copies of records. Without this protection, many dual eligibles would be unable to pursue their appeal rights.

We also strongly support treating oral inquiries as integrated reconsideration requests. Dual eligibles disproportionately face language and literacy issues, housing insecurity, behavioral health issues and other barriers that make it difficult for them to meet formal requirements such as written requests for reconsideration. Appeal rules need to address these realities.

We also particularly endorse the decision to allow expedited organization determinations and reconsiderations in post-service payment cases. As CMS has noted, financial need can be particularly pressing for a dual eligible who has paid for a denied service. Dual eligibles live on the edge financially. Paying for one service means not paying for prescription drugs, or for food or housing or other necessities essential for health. These considerations apply both for expedited organizational determinations and to post-service reconsiderations. To ensure full implementation of this provisions, we urge that CMS in its subregulatory guidance explain to plans that, for post-service payment issues, beneficiaries and providers can raise secondary impact on health based on the financial hardship of paying for services that were not initially covered.

(10) Unifying Medicare and Medicaid Appeals Subsequent to Integrated Reconsideration (NPRM at 55012-14)

We agree with CMS that a unified and integrated appeals process after a plan level appeal decision would be advantageous for beneficiaries trying to navigate a complicated system. Most dual eligible beneficiaries do not know whether a benefit is or should be covered by Medicaid or Medicare. The result can be errors, confusion and missed deadlines. We also agree that it could reduce administrative burden by eliminating appeals being filed with the wrong entity.

We appreciate the challenges of unifying what are now completely separate processes. Moreover, the Medicaid processes are state-administered and vary from state to state. Further a state would need to actively support an integrated process and invest resources and energy to achieve integration. While we understand CMS's reasoning that, given these realities, proposing a unified post-plan appeals process across states is not feasible at this time, we strongly encourage CMS to continue to pursue this path with interested states. The broad demonstration waiver authority available to the Center for Medicare and Medicaid Innovation could offer a vehicle for testing effective approaches.

Harmonizing hearing rights and processes: From a beneficiary point of view, auto forwarding after denials at the plan level and the right to a consolidated external review are key to making an appeal process navigable. As CMS is aware, the unified process used in the New York dual eligible financial alignment demonstration incorporated these elements and worked well for beneficiaries. Quality checks demonstrated that the delegation to state adjudicators resulted in Medicare decisions consistent with Medicare policy. Creating and implementing the New York process involved significant commitment by both the state and CMS and the result was carefully crafted. We urge CMS, while adapting to the

particular circumstances in different states, work with interested states to apply the hard-won learning from the New York demonstration.

Preserving the right to a hearing before the Secretary: the NPRM asks for feedback on the feasibility and desirability of the proposal to have a state entity with expertise in both Medicare and Medicaid coverage rules review all adverse integrated reconsiderations issued by the plan. CMS asks specifically about examples of state entities contracted to perform functions in federal programs. Justice in Aging has experience with a similar state-federal contracting arrangement in the Social Security context. The Social Security Administration contracts with disability determination services (DDS) in each state to make initial disability determinations for both Social Security Disability Insurance and Supplemental Security Income eligibility.<sup>12</sup> In our experience, this arrangement presents challenges because the DDS vary widely from state-to-state and SSA provides little oversight. In addition, the contracts are not public so it is challenging for advocates to help clients with DDS issues because they do not know what the DDS is required to do. However, we think these challenges can be mitigated with proper oversight, contracting requirements, transparency, and consumer protections. First, CMS should ensure that the entity has the necessary expertise in Medicaid and Medicare coverage rules by requiring it to be housed within the department administering the state's Medicaid program. In the DDS context, one of the challenges is that some states house their DDS in the labor department while others house them in the aging services department or the department of children and family services. As another example, some states have an advisory council for their DDS that includes beneficiaries and other stakeholders. We recommend CMS require such an advisory council for the entity that would be handling the post-plan appeals. Finally, CMS should require the contracts with the state entities to include all Medicare and Medicaid beneficiary protections such as the option for in-person hearings and language assistance.

We also note that in Medicare Part D, states have authority to conduct enrollment and recertification for the Low Income Subsidy program.<sup>13</sup> Although it is our understanding that states generally have not used this authority extensively, it is an instance where states have clear delegated authority to conduct eligibility reviews for a federal program.

Additional Proposals for Integration: We encourage CMS to explore additional steps toward integration that could be required of all D-SNPs, including those that are not FIDE SNPs or HIDE SNPs. The Act calls for integrated procedures “to the extent feasible” with the goal of making the process “easily navigable by the enrollee.” We view this directive as calling on CMS to provide as much integration in appeals as possible to as many D-SNP members as possible so that most of the 3.4 million D-SNP enrollees see a significant difference as a result of the Act's provisions. We have already proposed that, to better achieve this goal, the integration measures set out in the NPRM should be applied to all FIDE SNPs and HIDE SNPs, not just those with exclusively aligned enrollment. We further propose that CMS adopt measures that at least partially coordinate and simplify rules and procedures for enrollees in all D-SNPs. The requirement for assistance with Medicaid appeals, discussed earlier, is one such measure but there are others that would be both feasible and helpful for beneficiaries.

Several of the provisions that CMS is proposing for “applicable integrated plans” are also feasible for all D-SNPs and their adoption would make the appeal process more navigable to dual eligible beneficiaries. Examples include:

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<sup>12</sup> Social Security Admin., Disability Determination Process, [www.ssa.gov/disability/determination.htm](http://www.ssa.gov/disability/determination.htm).

<sup>13</sup> 42 U.S.C. § 1395w-114(a)(3)(B)(i) and (3)(b)(iii).



- Proposed § 422.630, which permits filing of a grievance at any time
- Proposed § 422.632, which provides for continuation of Medicare benefits pending appeal
- Proposed § 422.633(c), which requires plans, upon request, to supply the enrollee with a full case file free of charge and in a timely manner.

We also ask that all D-SNPs be required to issue notices in non-English languages according to the standard most protective of the beneficiary. If a state's translation requirements are more robust than those of CMS, then a D-SNP should be required to follow the state translation rules. This has been a standard requirement in the dual eligible financial alignment demonstrations and has worked well. A D-SNP enrollee should not be in a position where correspondence from the beneficiary's Medicaid plan is in the beneficiary's non-English language but correspondence from the D-SNP is only available in English.

Ombuds: Because a central goal of the Act is to make the Medicare and Medicaid programs more navigable for dual eligible beneficiaries, we take this opportunity to remind CMS of the valuable role an ombuds program could play in complementing the beneficiary assistance that CMS is requiring of D-SNPs in this rulemaking. The experience of the financial alignment demonstrations has shown that establishment and funding of state-specific ombuds with responsibility to assist beneficiaries with both benefits has been of significant value. While we recognize that creating dual eligible ombuds programs is beyond the scope of this rulemaking, we strongly urge CMS to develop and fund ombuds programs in every state where D-SNPs operate. Advocates have reported that ombuds programs in the financial alignment demonstration have reduced the need for appeals in many cases and have also identified systemic issues that interfere with integrated delivery of services.

### 3. Proposal for Prescription Drug Plan Sponsors' Access to Medicare Part A and B Claims Data Extracts (§ 423.153) (NPRM 55015)

We urge caution by CMS in implementing the statutory mandate to establish processes to provide Part A and Part B claims data to Part D plans. We recognize that, as a general rule, data sharing can improve care coordination and there has been some preliminary evidence of the value of sharing Medicare and Medicaid data in the dual eligible financial alignment demonstrations. The value of sharing claims data with Part D plans, however, is much more speculative.

We are cautious in part because of the track record of Part D in implementing basic Medication Therapy Management (MTM), which has not been outstanding, as noted multiple times by CMS and others. See, e.g. 2019 Call Letter (opioid concerns)<sup>14</sup> and 2016 MedPac report (critical review of MTM history).<sup>15</sup>

We have even greater concerns about use of data by Part D plans for care coordination. Part D plans have a very limited record of any care coordination activities other than MTM, and they most certainly have no experience in care coordination that involves their entire enrollee population. Care coordination has not been their mandate and, if CMS is sharing data for that purpose, we believe it should be in the context of broader regulations, informed by stakeholder input, defining what the

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<sup>14</sup> CMS, Announcement of Calendar Year 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Apr. 2, 2018), p. 251, available at [www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf](http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf).

<sup>15</sup> MedPac 2016 March Report, Ch. 13 p. 404, available at [www.medpac.gov/docs/default-source/reports/chapter-13-status-report-on-part-d-march-2016-report-.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/chapter-13-status-report-on-part-d-march-2016-report-.pdf?sfvrsn=0)

agency expects, what standards must be met, how Part D care coordination efforts would mesh with other coordination initiatives in Original Medicare, etc.

With or without more precise guidance on the care coordination role of Part D plans, we believe that, in light of their history, Part D plans will have more than enough challenges in effectively using claims data for the two purposes that are expressly set out in the Act. We are concerned that the NPRM proposes to expand the categories of permitted use of the data beyond MTM and care coordination, and urge the agency not to expand permissible uses until Part D plans can demonstrate that they can use claims data appropriately for these primary tasks.

We also note with concern that the regulation is silent on whether, in requesting the data, Part D plans need to show with any specificity how they intend to use the data and the results they expect. Once a request is granted, CMS proposes to provide standard data extracts that cover a wide swath of health information. In addition, the agency would provide those extracts for all plan members on a continuous basis whether or not the Part D plan needs the complete data set or needs information about its entire membership. While we recognize the administrative simplicity of this approach, we have concerns about sharing so much sensitive data when there is no showing that all the shared data are needed for stated goals. We urge CMS to ensure that data sharing only extends to what is needed to serve the goals of the Act. This helps prevent misuse by the plans. Also, as we are learning almost daily from newspaper headlines, the more entities that have and store sensitive information, the more chances there are for hackers and other bad actors to find and use that information. Our concern is heightened by the fact, which is acknowledged in the NPRM, that Part D plan affiliates and contractors are likely to also have access to the shared health claims information, increasing the potential for the information to be misused or stolen.

We also question whether proposed attestations are sufficient both to ensure that Part D plans do not use the information for purposes prohibited by the Act and also to ensure that adequate measures are taken to protect the information from disclosure to others. We ask that CMS require appropriate reporting and exercise robust oversight on both issues.

We urge CMS to move cautiously and deliberately, hewing closely to the statute, and carefully ensuring that Part D plans are prepared to use the health claims data appropriately and effectively. We expect that there will be significant learning as CMS rolls out this program. We urge that the agency start modestly so that mid-course corrections can be more easily accommodated.

## **B. Improving Program Quality and Accessibility**

1. Medicare Advantage and Part D Prescription Drug Plan Quality Rating System
  - c. Measure Level Star Ratings (§§ 422.166(A), 423.186(A))(NPRM at 55018)

CMS proposes to adjust the formula for cut points to make them more predictable and stable. We appreciate that cut points should be less sensitive to outliers. However, we are concerned about the proposal to cap cut points through “guardrails,” where cut points would be limited to movement under 5% in either direction. The purpose of the quality rating system is to depict an accurate measurement of Medicare Advantage and Part D plans that beneficiaries can evaluate when making coverage decisions. Limiting the ability of the star ratings to respond to industry changes raises concerns that the star ratings will be a less useful tool to compare plans. CMS should monitor the impact of any changes in the cut point methodology, and particularly ensure the cut points on measures do not get lower from year to

year. Such movement of cut points could inadvertently discourage plans from making improvements to attain higher star ratings.

d. Updating Measures (§§ 422.164, 423.184)

(1) Proposed Measure Updates

(b) MPF Accuracy (NPRM at 55021)

We support the changes to include both the magnitude and frequency of price discrepancies on the Medicare Plan Finder, and to expand the days' supply of claim included. Beneficiaries rely on the accuracy of the plan finder tool to make critical coverage decisions.

### **C. Clarifying Program Integrity Policies**

2. Medicare Advantage Risk Adjustment Data Validation Provisions (§§ 422.300, 422.310(e), and 422.311(a)) (NPRM at 55037)

We strongly support CMS's proposal to recover overpayments to MA plan based on extrapolated audit findings through the use of random sampling techniques. We also support the agency's plan to do so retroactively back to 2011. It is important for beneficiaries that MA plans are appropriately paid and that improperly paid funds are identified, calculated, and refunded to the Medicare trust fund. If plans do not operate efficiently and in accordance with program rules, enrollee costs rise and the entire Medicare system is weakened.

### **Conclusion**

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at [jgoldberg@justiceinaging.org](mailto:jgoldberg@justiceinaging.org).

Sincerely,



Jennifer Goldberg  
Directing Attorney