

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

April 6, 2020

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9115-P, Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Submitted electronically via [regulations.gov](https://www.regulations.gov)

**Re: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4190-P)**

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Notice.

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 been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Given our deep expertise on issues facing dual eligible beneficiaries, our comments primarily address the proposed regulatory actions aimed at curbing the growth of Dual Eligible Special Needs Plan (D-SNP) look-alike products. We have also addressed the Medicare Communications and Marketing Guidelines and cost-sharing issues that particularly impact low-income older adults.

[Contracting Standards for Dual Eligible Special Needs Plan \(D-SNP\) Look-Alikes \(§ 422.514\)](#)

We greatly appreciate the proposed regulatory actions aimed at curbing the growth of Dual Eligible Special Needs Plan (D-SNP) look-alike products. The commentary in the NPRM accurately notes that D-SNP look-alike products interfere with efforts to integrate delivery systems and offer person-centered care to dual eligible beneficiaries and undermine D-SNPs and other efforts to coordinate Medicare and Medicaid for this population.<sup>1</sup> Regulatory action is overdue, and we regard the look-alike proposals in § 422.514 as necessary. However, our experience in California and other states is that Medicare Advantage organizations offering look-alike products need greater restrictions to stop them from designing and marketing look-alike plans to dual eligible beneficiaries. Look-alikes in earnest began in California as a way around state policies that limited the availability of D-SNPs in order to encourage enrollment in the state's Medicare-Medicaid Plans (MMP). When designing and implementing these

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<sup>1</sup> 85 Federal Register 9020

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rules, CMS should create protections that are strong enough to ensure that Medicare Advantage organizations do not again find ways around the rules. We urge CMS to strengthen its proposed rules by applying § 422.514(d) to all states, setting a more appropriate threshold for determining what constitutes a look-alike, and imposing more beneficiary protections in its crosswalk guidance.

### **Regulations Should Apply to All States**

Proposed § 422.514(d) exempts Medicare Advantage plans in states that do not offer D-SNP or Medicare-Medicaid plan (MMP) products. The proposed enrollment requirement should apply to all states, regardless of the Medicare enrollment options in that state. In analyzing this issue, it is important to focus on the two key elements of look-alikes: they are designed to attract dual eligible members and they are designed to circumvent both federal and state requirements aimed at assuring that the special needs of those dual eligible members are addressed. The harm to dual eligibles that this evasion of safeguards by look-alike products poses, though heightened when more integrated enrollment options exist, is present nonetheless in the absence of those options. Further a policy of excluding states where no D-SNPs or MMPs exist may well discourage the expansion of D-SNPs into those states that currently have none. Plans would have no incentive to introduce D-SNPs when they could operate look-alikes instead.

States should be able to exercise oversight and enjoy the freedom to set a broader strategy to coordinate care for their dual eligible populations without worrying about the potential proliferation and interference of look-alike products. State approaches may vary. A state, like Washington State, may want to pursue an integration strategy using a managed fee-for-service model, rather than the route of D-SNPs or MMPs. All states should be free from interference by look-alikes no matter what routes those states have chosen to address the needs of their dual eligible beneficiaries. In every state, CMS and states need to work together to improve the way they serve dual eligibles, the highest need, highest cost portions of both Medicare and Medicaid beneficiaries. Limiting look-alike regulation to only some states impedes progress toward that end.

### **A 50% Threshold Should Be Set for Determining Look-Alikes**

In its proposal, at § 422.514(d)(1) and (2), CMS sets an 80% threshold of dual eligible enrollment to determine whether a Medicare Advantage plan is a look-alike. The proposal does not go far enough to capture look-alike products that enroll a disproportionate percentage of dual eligible beneficiaries. We recommend that CMS set a 50% threshold instead. When setting a threshold, consideration should be given both to the proportion of dual eligibles among the Medicare population more broadly and the percentages enrolled in Medicare Advantage. Data indicate that dual eligibles constitute about 10% to 25% of overall enrollment in Medicare Advantage; there is no county in the country where average dual eligible enrollment exceeds 50%.<sup>2</sup> Therefore, a more realistic measure for identifying a look-alike, better tailored to these enrollment figures, would be 50%. The 80% threshold would fail to capture a significant

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<sup>2</sup> June 2019 [MedPAC Report to Congress, Chapter 12](#).

number of plans that operate as look-alikes.. It is difficult to believe that, for example, a plan with three out of four members who are dually eligible isn't specifically designed to attract this population.

Using an 80% threshold is particularly concerning because the only consequence of exceeding the threshold is an automatic crosswalk to the same plan sponsor's D-SNP the following plan year. Thus, plan sponsors have every incentive to market aggressively-- just not too aggressively-- to dual eligibles so they can gain market share, while not being treated as look-alikes for as long as possible. If some year down the road, a plan crosses the 80% threshold, the sponsor will need to submit to a D-SNP regime but will have already captured a significant dual eligible enrollee population without D-SNP beneficiary protections, and the sponsor will keep those enrollees through crosswalk. Only a more realistic measure, like 50%, will protect beneficiaries from being pawns in a regulatory game of cat and mouse.

We note that CMS has proposed in § 422.(d) to analyze both the projected membership as well as the actual membership of a plan in January to determine if a plan meets the threshold for a look-alike. We support this two-pronged approach, which we believe is necessary and important, but we have concerns that these measures still allow a potential look-alike ample time to market during the Medicare Advantage Open Enrollment Period, as during the Special Enrollment Periods for Low-Income Subsidy (LIS) enrollees, ultimately enrolling a higher percentage of dual eligible beneficiaries after the January evaluation.

### **Crosswalk Proposals Should be Strengthened**

With respect to the crosswalk proposals in § 422.514(e), we are generally supportive of efforts to move dual eligibles out of look-alikes, but believe that the requirements proposed in (e) should be strengthened. Our recommendations fall into two categories: (1) operationalizing the crosswalks and (2) information provided to consumers during the crosswalk.

When operationalizing the crosswalks, the default should be enrollment into a D-SNP operated by the same plan sponsor. Plans should not be permitted to funnel dual eligibles into other Medicare Advantage plans that are not integrated products. Crosswalks should only happen when they protect and ease the burden on beneficiaries. A crosswalk from one non-integrated product to another, particularly when integrated plans are available in a service area, whether or not operated by the same plan sponsor, does not advance coordination for dual eligible beneficiaries,

We also recommend that CMS set standards for significant overlap of provider networks between the look-alike and receiving plans before initiating the crosswalk. We propose a 90% overlap. Because the new plan is sponsored by the same parent organization, that organization can adjust its networks to meet this standard. Further, we encourage CMS to issue crosswalk timing guidance to states so that crosswalks for dual eligible beneficiaries coordinate with any transitions that states are proposing in Medicaid enrollment. Many states continue to shift the ways their dual eligibles receive care, and one ultimate aim should be to minimize the number of transitions—and corresponding potential disruptions in care—a consumer experiences over a short period of time.

In addition to operationalizing the crosswalk, we believe information provided to consumers during the crosswalk process should be bolstered. We welcome the proposal in § 422.514(e)(2)(ii) that the Annual Notice of Change (ANOC) describe differences in provider networks, and we recommend that CMS take an additional step by requiring the ANOC to specifically identify primary care providers (PCPs) and specialists whom the dual eligible has seen twice or more in the past twelve months who are not part of the network of the plan into which the beneficiary will be crosswalked. This targeted information is necessary if a beneficiary is to make an informed choice about whether to participate in the crosswalk and will also prevent surprise access to care issues in the early months of enrollment.

### Requirements for Medicare Communications and Marketing (§§ 422.2260–422.2274; 423.2260– 423.2274)

While we recognize CMS’s intent is to codify existing MCMG rules into regulatory guidance, Justice in Aging is concerned that many of the proposed rules do not adequately protect Medicare enrollees and that many necessary protections, including some that were in previous versions of guidance, are not being codified. We urge the agency to use this opportunity in the regulatory process to address existing limitations in marketing rules/guidance in consumer protections found in the current MCMG and strengthen its proposal in § 422.2262(a)(1)(xvi) around marketing restrictions with respect to D-SNP lookalikes.

#### **Addressing Existing Marketing Limitations**

We remain concerned by changes introduced into MCMG guidance for the 2020 plan year, including the blurring between marketing and education, the removal of non-English translation disclaimers, and the lack of information regarding supplemental benefits. We ask CMS to address these and other issues in its final regulations, as discussed below.

The NPRM incorporates instructions to plans regarding disclaimers on materials and content. We urge CMS to remind Medicare Advantage plans and other covered entities about their obligations to comply with notice requirements under Section 1557 of the Affordable Care Act, including “taglines” and disclaimers in the top 15 languages. We also urge CMS to work with the Office for Civil Rights to conduct enforcement and oversight to ensure Medicare beneficiaries with limited English proficiency are able to access and understand important information about their coverage. Of particular concern is the need for stronger translation requirements. We urge CMS to take this regulatory opportunity to revisit and update the triggers set forth in 42 C.F.R. § 422.2268(a)(7). We recommend setting a threshold of either 5% or 1,000 people, whichever is lower, in a service area who speak a language other than English as triggering the translation requirement for vital documents. The current 5% trigger neglects many substantial non-English speaking communities throughout the country, leaving those limited English proficient older adults and people with disabilities without appropriate language access in documents from their plans.

In addition, CMS incorporates existing guidance into its rules around how plans can contact beneficiaries, specifically allowing plans to contact beneficiaries in another line of business, including Medicaid plans, to discuss Medicare options. We believe the regulations must include limitations to this

broad exception to the protection of beneficiaries from an onslaught of unsolicited marketing. The exception was created at a time when far fewer dual eligibles were enrolled in Medicaid managed care. Given the proliferation of dual eligibles enrolled in Medicaid managed care organizations—in 2016 as many as 28 states required dual eligibles to be enrolled in Medicaid managed care<sup>3</sup>—we urge limiting plan outreach/marketing to once a quarter, a limitation that corresponds with the LIS special enrollment periods. Our proposal gives plan sponsors an opportunity to reach out to their members while protecting those members from a barrage of unwanted solicitations by plan agents and brokers.

We also object to how “marketing” and “communications” documents are classified for review; the lack of guidance to MA plans on marketing of supplemental benefits; elimination of the requirement that plan sponsors report to CMS “any co-branding relationships, including any changes in or newly formed co-branding relationships, prior to marketing them;” elimination of the requirement that “Plans/Part D sponsors may only advertise in their defined service area, unless unavoidable (e.g., advertising in media with a national audience or with an audience that includes some individuals outside of the service area, such as a Metropolitan Statistical Area that covers two regions);” elimination of restrictions regarding marketing of plan rewards and incentive programs; elimination of certain restrictions applicable to provider-initiated activities; and elimination of requirement that plan materials include a “benefits disclaimer” that previously required specific text on marketing pieces listing 10 benefits or more. Both separately and combined, the elimination of all these consumer protections means less transparency and more pressure on the most vulnerable beneficiaries. For Medicare freedom of choice to be genuine, robust consumer protections must be in place so that beneficiaries can have the information they need, clearly presented without sales pressure. These measures are a step in the wrong direction.

### **Marketing Restrictions for Look-Alikes**

We appreciate the measures proposed in § 422.2262(a)(1)(xvi) to limit the ability of look-alike plans to claim they have a relationship with a state Medicaid agency or are designed for dual eligibles, but we believe more must be done to protect dual eligibles from misleading marketing practices.

We recommend, for example, imposing clear requirements on all non-integrated Medicare Advantage plans that when an agent/broker is disenrolling a dual eligible from an integrated product, like a D-SNP, MMP, or PACE plan, the broker/agent must explain to the beneficiary what they are disenrolling from and that they will be enrolling into a non-integrated product and the potential implications on their care. This will require plan agents and brokers to determine whether a beneficiary is a dual eligible. From there, we recommend that the agent or broker be required to explain both orally and in writing that the new plan does not have a contract with the state to coordinate Medicaid benefits. If there are integrated products offered in the service area, we suggest that the written document should list them and provide contact information. Such a document should be standard, prepared by the plan, and reviewed by CMS. We also believe these points should be reiterated during the outbound enrollment verification communication, and if a plan chooses to deliver those communications by phone, actual contact with the enrollee should be required. The plan representatives conducting the outbound call should be trained in how any supplemental benefits offered by the plan overlap or interact with

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<sup>3</sup> [https://www.ahip.org/wp-content/uploads/2018/09/IB\\_Medicare-Medicaid\\_DESDM.pdf](https://www.ahip.org/wp-content/uploads/2018/09/IB_Medicare-Medicaid_DESDM.pdf)

Medicaid benefits and affirmatively aid the beneficiary in understanding that basic relationship. The plan initiating the enrollment transaction into a non-integrated product should be responsible for ensuring any dual eligible who enrolls, at a minimum, understand how the plan does and does not coordinate Medicaid benefits

## Other Issues

### **Special Supplemental Benefits for the Chronically III (SSBCI)**

We recognize that SSBCI have the potential to benefit individuals with the greatest health care and related social needs. We urge, however, that CMS remain vigilant and proactive to ensure that people dually eligible for the same benefits under Medicaid are not burdened or at a disadvantage by having duplicative coverage. We have seen many instances where SSBCI benefits have actually made access to services more difficult for dual eligible beneficiaries. For example, dental benefits, where a Medicare Advantage plan covers part of a needed treatment plan and the dual eligible must switch to a Medicaid provider to complete the treatment after the limited supplemental benefit is exhausted. We note that the potential for confusing and often useless duplicative coverage is particularly high in look-alike plans since they are not under any constraints by CMS or the states requiring meaningful SSBCI benefits that complement state Medicaid coverage.

We also reiterate our concerns that such benefits have not been extended to the majority of individuals who choose to remain in original Medicare and that their availability and accessibility even within Medicare Advantage is limited. We urge CMS to support expanding availability of these benefits to all Medicare enrollees who could benefit through both legislation and administrative means such as CMMI demonstrations.

We do not object to CMS allowing plans to target chronic conditions other than those that are included in the Medicare Managed Care Manual (Chapter 16b). We also support CMS' proposal to require plans to make information and documentation used to make eligibility determinations available to CMS. We urge CMS to make such reporting mandatory so that data are available to examine the efficacy of Medicare Advantage plans' administration of SSBCI and to inform expansion of SSCBCI into original Medicare.

### **Automatic Escalation to External Review Under a Medicare Part D Drug Management Program for At-Risk Beneficiaries**

We support the Secretary exercising his discretion under the statute to provide for automatic escalation of drug management program appeals to external review. We further urge the Secretary to either exercise his authority or support legislation to extend such auto-escalation to external review for *all* adverse appeal decisions regarding Part D drugs, similar to the rules surrounding Medicare Advantage appeals.

### **Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System**

The Proposed Rule includes updates to the methodology and measures for the quality rating system for MA and Part D plans (“Star Ratings program”). We appreciate CMS’ proposal to increase the weight of patient experience/complaints and access measures, as these reflect key considerations for beneficiaries when evaluating and choosing a plan under these programs. The existing measures within these categories include important metrics such as ease of getting needed care, members’ ratings of quality of care, and more. We are also pleased that CMS will continue to measure plans on their responses to appeals, including whether MA plans make timely decisions about appeals (measure DMC16).

We also support expanding the existing Health Outcomes Survey Measures (HOS) (improving or maintaining physical health and mental health) to persons under the age of 65 years. Medicare and its various plans are important resources for persons with significant disabilities under the age of 65, including those who are dually eligible for Medicare and Medicaid.

We encourage CMS to consider an additional measure for MA plans that would track what percentage of denied claims are elevated to review by an independent entity. The Reconsideration to an Independent Review Entity (IRE) stage is a critical step in ensuring that beneficiaries who have had claims denied are able to have a third-party, objective review of their appeal. When evaluating plans, beneficiaries should be able to understand if a given plan issues a large number of denials at redetermination that may indicate barriers to access care.

In future iterations of the Star Ratings system, we recommend that CMS add measures that examine access to rehabilitation in inpatient settings (IRFs), as well as outpatient or home-based settings. We also encourage CMS to adopt measures to assess MA plan compliance with the *Jimmo v. Sebelius* settlement, which explicitly rejects an “improvement standard” and clarifies coverage for skilled services provided to Medicare beneficiaries that improve, maintain, and prevent deterioration of function in skilled nursing facilities, home health agencies, and outpatient clinics. Such measures should focus on both access to care and the functional outcomes of rehabilitation care in these post-acute care settings.

#### **Permitting a Second, “Preferred”, Specialty Tier in Part D**

We are concerned that CMS’s proposal to permit a second specialty tier will further complicate an already complicated benefit without any guarantee of meaningful savings or other benefit for Part D enrollees. We disagree with CMS that this would “strike an appropriate balance between plan flexibility and Part D enrollee access to drugs.” In fact, because drugs on this new proposed tier would be subject to the same cost-sharing threshold of at least 25% of the costs of very expensive drugs, we do not see any improvement for enrollee access.

We urge CMS withdraw this proposal and instead, eliminate specialty tiers which have very high and unpredictable co-insurance. At the very least, CMS should allow tiering exceptions for specialty tier drugs, both as a matter of fairness and to promote affordable access to high-cost medications. We also recommend CMS focus on enrollees’ access to prescription drugs by improving the Part D appeals process by requiring individually-tailored notices at the pharmacy counter and requiring that denials at the pharmacy counter trigger the appeals process.

### **Beneficiary Real Time Benefit Tool (RTBT)**

CMS proposes that each Part D plan implement a beneficiary RTBT that will allow enrollees to view plan-provided, patient-specific, real-time formulary and benefit information by January 1, 2022. While we appreciate efforts to provide more information to Medicare beneficiaries, and generally support requiring plans to implement an RTBT, we urge CMS to focus on providing individuals with such information *prior to* enrollment through the Medicare Plan Finder (MPF). CMS should require plan sponsors, at the very least, to have formulary alternatives made available through the MPF based upon the particular drugs being compared. Part D plans change their formularies, benefit and cost-sharing structures annually, making careful selection of plans so critical, prospective plan enrollees should have access to the same information that actual plan enrollees do.

### **Service Category Cost Sharing Limits for Medicare Parts A and B Services and per Member per Month Actuarial Equivalence Cost Sharing**

As a general comment, we object to allowing cost-sharing as high as 50% for certain services, even with a lower applicable MOOP amount. Requiring significant cost-sharing, let alone up to half of costs of a given service, means that the majority of Medicare beneficiaries who are living on limited fixed incomes with little or no savings will not be able to get medically necessary care because they cannot afford the coinsurance amount. We also oppose allowing multiple MOOP levels with varying levels of cost-sharing for varying services because it makes comparing and choosing plans more difficult and puts more burden on the enrollee to understand what are already complicated coverage terms.

We are very concerned about the approach CMS is taking concerning MA cost-sharing for dialysis. In particular, CMS appears to propose to allow MA plans to charge up to 20% coinsurance for dialysis, regardless of an MA plan's MOOP level. We urge CMS to take action to prevent discriminatory benefit design in MA plans relating to people with ESRD by prohibiting – or at the very least minimizing – cost-sharing for dialysis. Before MA plans submit their bids for 2021, CMS should issue clear statements to plans that benefit designs that charge 20% coinsurance for dialysis will be deemed discriminatory and will not be allowed.

We also oppose CMS's proposal to allow MA plans with a lower MOOP to charge up to 20% coinsurance for home health services, for which original Medicare charges no cost sharing. Applying a MOOP should not be used to justify an MA plan charging cost-sharing for services that are insulated from any costs in original Medicare. We urge CMS to prohibit cost-sharing for home health services in MA plans.

In addition, CMS is proposing to allow an MA plan to “establish cost-sharing for specific items of DME that exceed the cost sharing under original Medicare.” Allowing cost-sharing to be applied to certain DME, which is used by individuals with certain conditions, can constitute discriminatory cost-sharing on its face. We urge CMS not to allow this proposal or, at the very least, require uniformity with respect to cost-sharing for DME.

## **Medicare Advantage (MA) and Cost Plan Network Adequacy**

We urge CMS not to move forward with its proposals to codify network adequacy methodology for Medicare Advantage plans as they would effectively dilute network adequacy standards. Network adequacy is a key beneficiary protection that should be strengthened and never compromised.

More specifically, we oppose the proposals

- to reduce the required percentage of beneficiaries that must reside within the maximum time and distance standards from 90% to 85% in rural areas. If an MA plan sponsor cannot contract with an adequate number of providers within reasonable time and distance standards to the maximum number of enrollees it should not be allowed to offer a plan in the area.
- To allow MA plans to receive a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers for Dermatology, Psychiatry, Cardiology, Otolaryngology, and Neurology. If CMS chooses to adopt it, we urge CMS not to expand this credit to other specialty provider types.

We also urge CMS to include post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs) in the facility specialty types as part its network adequacy reviews. In addition, in order to ensure that MA plan enrollees have adequate access to plan providers, we urge CMS to focus its attention on the undue burden that inaccurate, hard-to-access, and non-searchable provider directories place on beneficiaries and prohibit mid-year network provider terminations.

Finally, the current COVID-19 crisis has highlighted the importance of access to telehealth. We generally support increasing access to care using telehealth, but such access should not come at the expense of providing quality care to enrollees. In particular, we strongly urge CMS to remind plan sponsors of their language access obligations under Section 1557 of the Affordable Care Act and Title VI and ensure that, both in telehealth and in-person visits, plans are meeting such obligations, particularly around the provision and use of qualified interpreters.

### **Proposed Changes to the Programs of All-Inclusive Care for the Elderly (PACE) – p. 9124**

[CMS proposes to reduce the administrative burden for PACE organizations by proposing to allow service delivery requests to be approved in full by an interdisciplinary team (IDT) member at the time the request is made. This proposal eliminates the requirement that the IDT conduct a reassessment of the participant for service delivery requests that can be approved. We are also proposing to enhance participant protections by improving the participant appeals process, adding additional participant rights, increasing requirements related to the provision of services, and ensuring PACE organizations appropriately document care in the medical record while maintaining original communications from caregivers and others. CMS is also proposing to bolster CMS's ability to access records, improve the regulatory framework relating to required services in PACE, and set out appeal processes for PACE organizations following certain enforcement actions.]

## Conclusion

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact Amber Christ, Directing Attorney, at [achrist@justiceinaging.org](mailto:achrist@justiceinaging.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with the first name "Jennifer" and last name "Goldberg" clearly distinguishable.

Jennifer Goldberg

Deputy Director