September 30, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Dear Acting Administrator Slavitt:

The undersigned organizations share a commitment to advancing the health and economic security of people with Medicare and their families. We are writing to comment on Centers for Medicare & Medicaid Services (CMS) policies involving seamless conversion, a practice that allows select insurers to auto-enroll newly eligible Medicare beneficiaries in an issuer's commercial or Medicaid managed care product into one of the same company's Medicare Advantage (MA) plans. Our organizations greatly appreciated having the opportunity to meet with the Medicare Enrollment and Appeals Group to learn more about CMS policies and practices related to seamless conversion in late August.

As you know, seamless conversion is authorized under the Balanced Budget Act of 1997 and CMS guidance. Medicare Advantage Organizations (MAOs) that wish to exercise this option must follow the instructions set forth in the Medicare Managed Care Manual.[1] Recently, CMS reminded MAOs about the availability of this practice in the 2016 Advance Notice and Announcement of the Call Letter, specifically about MAO's ability to use seamless conversion to transition enrollees in Medicaid managed care plans to integrated Dual Special Needs Plans (D-SNPs) once the enrollee is Medicare eligible.[2] We share CMS' commitment to promoting care integration and smooth transitions to Medicare for this vulnerable population. Nevertheless, our organizations have strong reservations about the use of seamless conversion.[3]

We believe CMS should advance policies that encourage people new to Medicare to make an active and informed choice about the coverage option(s) that are right for them, selecting among Traditional Medicare, Medicare Advantage plans (including integrated Medicare-Medicaid options), supplemental Medigap policies, and stand-alone Part D prescription drug plans. In general, we do not believe that opt-out mechanisms, as allowed through seamless conversion, facilitate this type of active decision-making. Further, it concerns us that people new to Medicare are auto-enrolled in MA plans through a seamless conversion process that does not

[1] 42 C.F.R. §422.66(d); See: Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 40.1.4 (last updated September 2015), available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2016_MA_Enrollment_and_Disenrollment_Guidance_9-14-2015.pdf

[2] See: Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter (February 2015, pg. 111), available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf; Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (April 2014, pg. 114), available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf

[3] For example, see comments by the Medicare Rights Center on the Advance Notice of the 2016 Call Letter (March 2015, pg. 9), available at: http://www.medicarerights.org/wp-content/uploads/2015/03/medicare-rights-advance-2016-call-letter-Comments.pdf. We recognize that similar passive enrollment/opt-out procedures are used for employee-sponsored retiree plans. Our concern does not extend to this context where there are very different considerations for newly eligible Medicare beneficiaries.

necessarily give preference to their current health care providers, medications, needed services, and so forth, depending instead only on whether the MA plan is owned and operated by the same parent organization as their previous coverage.

As such, we continue to urge the agency to proceed with caution and to allow this practice in only the most limited circumstances. Making a choice about one's Medicare coverage when initially eligible is critically important, particularly in states with limited Medigap enrollment rights. In many states, a beneficiary will have limited opportunities to purchase a Medigap policy at a later date if he or she initially opts for or is converted into an MA plan. These considerations must be made clear to people newly eligible for Medicare so that they can make a fully informed choice among their Medicare Advantage and supplemental Medigap options.

We understand that CMS is in the process of revising the agency's seamless conversion policies. We appreciate this effort, and urge the agency to, as soon as practicable, issue a new policy that incorporates the additional consumer protections outlined below. Until then, we encourage CMS to limit further approval of new applications by MAOs to institute seamless conversion programs.

Further, we strongly support CMS' plans to publicly release information on the MAOs approved to use seamless conversion; we urge the agency to act quickly and to ensure this release includes information on the approved MAOs, the approved conversion type (from commercial to MA versus Medicaid managed care to MA), the affected geographic regions, and the number of affected beneficiaries. With access to this information, our organizations, State Health Insurance Assistance Programs (SHIPs), and others will be better equipped to assist newly eligible beneficiaries and their families.[4] In addition, we encourage CMS to consider the following recommendations as the agency reviews its policies on seamless conversion:

- **Require write-in confirmation:** Current guidance on seamless conversion requires MAOs to send a minimum of one written notification to enrollees who will be seamlessly converted explaining the beneficiary's rights to opt-out or decline auto-enrollment. As opposed to relying on an opt-out—which promotes passive decision-making—we urge CMS to require that the MAO collect written confirmation from the beneficiary to proceed with enrollment—which instead promotes active decision-making and ensures that individuals are aware of their enrollment.

- **Allow a Special Enrollment Period (SEP) for those seamlessly converted:** Even with multiple notices and enhanced outreach, we expect that some individuals auto-enrolled in an MA plan may be unaware that they have been seamlessly converted until they are denied services or receive a bill for unexpected out-of-network charges. Given that these individuals did not actively elect MA coverage, we urge CMS to establish a Special Enrollment Period (SEP) allowing seamlessly converted individuals to elect another MA plan or Traditional Medicare with a stand-alone Part D plan.

[4] Recent news reports reflect concern, particularly among SHIP counselors, with the lack of information currently available. See, e.g., *North Carolina Health News* story http://www.northcarolinahealthnews.org/2016/09/26/letter-from-insurer-could-contain-unwanted-medicare-conversion/ , *Miami Herald* story http://www.miamiherald.com/news/nation-world/national/article102738057.html, and *Money Magazine* column http://www.reuters.com/article/us-column-miller-medicare-idUSKCN11L1CD. Also, see the Center for Medicare Advocacy's Weekly Alert "Case Study: Enrolled In a Medicare Advantage Plan Without Her Knowledge Through 'Seamless Conversion Enrollment'" (June 1, 2016), available at: http://www.medicareadvocacy.org/case-study-enrolled-in-a-medicare-advantage-plan-without-her-knowledge-through-seamless-conversion-enrollment/.

- **Require additional notification and outreach to newly eligible beneficiaries:** In the absence of write-in confirmation (as recommended above), we strongly encourage CMS to require outreach that goes beyond the current minimum of one written notification. We understand that most MAOs currently using seamless conversion are voluntarily enhancing outreach to enrollees scheduled for auto-enrollment, such as through multiple phone calls and mailings. We are encouraged by these practices and suggest that CMS require them of all involved MAOs. We also ask that seamless enrollment be prohibited if MAOs are unable to reach individuals as evidenced by return of undeliverable mail. Experience with passive enrollment in the financial alignment initiative for dually eligible beneficiaries has shown that moving these individuals without their knowledge can result in problems with access to care.

- **Require notification tailored to conversion type:** We understand that CMS currently approves seamless conversion arrangements for those transitioning from commercial coverage (including Marketplace coverage) to MA and for those moving from Medicaid managed care products to MA. We appreciate that CMS reviews the notices developed by participating MAOs, and we encourage the agency to consider developing model notices with input gathered from beneficiary focus group testing, consumer advocates, and readability experts.

  Further, we encourage CMS to ensure that approved notifications are tailored to specific transitions. For example, individuals transitioning from Qualified Health Plans (QHPs) to Medicare have different considerations than those transitioning from Medicaid, particularly expansion Medicaid, to an integrated D-SNP. A QHP enrollee may need to consider how to terminate their QHP and how their family members will retain coverage post-termination; whereas, a Medicaid enrollee may need to assess his or her ability to continue care with a long-term services provider or a primary care provider in a specific MA plan. Seamless conversion notices should reflect the considerations unique to those individuals leaving commercial coverage as opposed to those leaving one private Medicaid product for another.

- **Regularly release data and information on the use of seamless conversion:** As noted above, we appreciate that CMS plans to release information on approved seamless conversion arrangements, and we believe that enhanced transparency related to this practice is a paramount concern, both to prepare those who counsel beneficiaries and to lessen the potential for unnecessary alarm among newly eligible beneficiaries. As such, information pertaining to seamless conversion arrangements should be made publicly available on a regular basis. Beyond approved arrangements, we encourage CMS to release annual data on the number of individuals seamlessly converted, on the number of opt-outs, on beneficiary complaint tracking, on inquires made to 1-800-MEDICARE and the Medicare Ombudsman, and other relevant topics.

- **Create 1-800-MEDICARE trainings and scripts:** We strongly encourage CMS to develop specific trainings and scripts on seamless conversion for 1-800-MEDICARE call center employees. Importantly, call center employees should be prepared to field beneficiary inquires about seamless conversion, including on beneficiary opt-out rights. Additionally, 1-800-MEDICARE is the gateway for tracking formal beneficiary complaints, through the Complaint Tracking Module (CTM), and it is critically important that call center employees are prepared to identify and appropriately escalate relevant complaints and grievances.

- **Publish the approval criteria and enhance monitoring and oversight:** We understand that CMS currently allows one-time applications for MAOs that opt to use seamless conversion. We encourage the agency to implement more stringent application practices, such as by requiring annual submission and review. Further, CMS should publish the specific criteria used by the agency to evaluate and approve a

seamless conversion application. In addition, we urge CMS to develop protocols for enhanced monitoring of seamless conversion, to ensure that MAOs are both employing conversions for only the approved transitions and following through on outreach and notice commitments.

The variables that an individual new to Medicare must consider to make an informed coverage choice extend well beyond the parent company that provides a person's current health insurance. Like CMS, we encourage people new to Medicare to actively consider out-of-pocket costs, coverage rules and restrictions, and provider options when choosing how to receive their Medicare, and we strongly encourage that beneficiaries engage in this evaluation process each and every year. As currently constructed, seamless conversion arrangements are not well suited to promote these important goals. We look forward to continuing this dialogue and working with CMS to strengthen seamless conversion policies. Thank you.

Sincerely,

Medicare Rights Center
Justice in Aging
Center for Medicare Advocacy
National Council on Aging

CC:

Sean Cavanaugh, Deputy Administrator & Director, Center for Medicare
Kevin Couinhan, Director & Marketplace CEO, Center for Consumer Information and Insurance Oversight
Vikki Wachino, Deputy Administrator and Director, Center for Medicaid and CHIP Services
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