Center for Medicare Advocacy
Advancing Access to Medicare and Health Care

April 6, 2020

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4190-P
7500 Security Boulevard
Baltimore, MD 21244-8013

Re: CMS-4190-P

Dear Administrator Verma:

The Center for Medicare Advocacy (Center) is pleased to provide the Centers for Medicare & Medicaid Services (CMS) comments to the proposed rule entitled 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).

The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

A. Special Supplemental Benefits for the Chronically Ill (SSBCI) (p. 9011)

Broadly speaking, we recognize that SSBCI have the potential to benefit individuals who may have access to them, and may be found eligible for them in a given plan. However, we reiterate our concerns that such benefits have not been extended to the majority of individuals who choose to remain in traditional Medicare. We understand that legislation would likely be required in order to broadly effectuate such changes, but urge CMS to support such expansion of benefits, and to use means at its disposal – including CMMI demonstrations – to move Medicare coverage in this direction.

Also, as referenced below in comments under Medicare Communications and Marketing Guidelines below, we continue to urge CMS to issue guidance concerning the marketing of SSBCI.[1]

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, although such reporting should be mandated, rather than made available upon request. If CMS (or academic researchers or other interested parties) wish to collect data in order to examine the efficacy of MA plans' administration of SSBCI, as well as gathering data that can be used as justification to expand such benefits to individuals in traditional Medicare, such data should be broadly collected, rather than piecemeal and only at CMS' request.

E. Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes – p. 9018

The Center supports the CMS proposal to limit MA plans that are "look-alike" dual eligible plans. The Center has been concerned about these plans that market aggressively to dually eligible individuals, are made up of mostly dual eligible beneficiaries, but are not subject to the federal regulatory and state contracting requirements applicable to D-SNPs, and do not provide Medicaid integration. We agree with CMS that the "look-alike" D-SNPs impede the ability of states and CMS to meaningfully implement existing and new statutory requirements for D-SNPs that Congress created by allowing plans that fail to meet the requirement to create look-alikes instead.

Under the proposed rule, CMS proposes to not enter into or renew a contract for an MA plan that is a non-SNP plan that either: projects in its bid that 80 percent or more of the plan's total enrollment are enrollees entitled to medical assistance under a state plan under Title XIX, or has actual enrollment, as determined by CMS using the January enrollment of the current year, consisting of 80 percent or more of enrollees who are entitled to medical assistance under a state plan under Title XIX, unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals at the time of such determination.

While the Center appreciates CMS's effort to clamp down on D-SNP look alike plans, we believe that a stricter threshold number is needed for which plans constitutes a look-alike. The proposed 80% threshold of dual eligible enrollment does not go far enough to limit the look alike plans. We recommend a 50% threshold, especially considering the proportion of duals among

[1] Center for Medicare Advocacy comments to CMS on MCMG (April 2019) available at: https://www.medicareadvocacy.org/center-comments-on-medicare-marketing-guidelines/.

the Medicare population more broadly and the MedPAC analysis demonstrating that dual eligibles constitute about 10-25% of Medicare Advantage (MA) enrollment and in no county exceeds 50%. Therefore, setting the threshold at 80% will fail to capture many of the look-alike plans that this proposal is aimed at addressing. In addition, since CMS will evaluate January enrollment, a lower threshold is necessary because plans have ample time to market during the open enrollment period and the quarterly Low-Income Subsidy (LIS) Special Enrollment Period (SEP), ultimately enrolling a higher percentage of duals. A lower threshold also disincentivizes plans from gaming the system by enrolling slightly less than the bar, e.g. enrollment of duals constitutes 75% of a lookalike's membership.

The Center supports CMS's proposal to curb these look-alike plans, but asks that CMS go further to promote integrated and coordinated care for duals. This includes applying regulations to all states and not exempting states that do not have D-SNPs or Medicare-Medicaid Plans (MMPs); these proposed enrollment requirements should apply to all states. States should be able to exercise oversight and have freedom to set a broader strategy to coordinate care for their dual eligibles without worrying about potential proliferation of look-alike products.

CMS is also proposing to crosswalk dual eligibles currently enrolled in look-alikes to another Medicare Advantage or Part D plan offered by the same organization. They would still have the opportunity to choose another plan since the crosswalk is timed to occur with the annual coordinated election period. Receiving MA plans would need to have a combined Part C & D premium of $0 and are required to send an Annual Notice of Change (ANOC) to the cross walked beneficiary.

While we generally support the proposed measures around receiving plans having $0 premiums and notices/Annual Notice of Change (ANOC) requirements describing differences between the look-alike and receiving plan. We suggest the ANOC include a discussion of providers known to not be in the receiving plan's network, focusing specifically on PCPs and specialists who the beneficiary has seen twice or more in the past year.

We also recommend setting a requirement of 90% overlap of network providers between the look-alike and receiving plans. We believe that, coupled with a robust ANOC, will help smooth the transition for beneficiaries. If 90% provider overlap is not met, we recommend that the dual eligible is defaulted instead back to traditional Medicare since MA plans, including D-SNPs, can continue to market to duals who are enrolled in their Medicaid plans.

We would like to stress the importance of providing beneficiaries proper notice of other plan options in cases where a crosswalk is occurring into a D-SNP offered by the same MA organization. Plans should not be able to funnel duals into other MA plans when a more integrated option exists. This would be essentially rewarding the MA organizations that had D-SNP look-alikes.

III. Implementation of Several Opioid Provisions of the SUPPORT Act - p. 9025

B. Beneficiaries with History of Opioid-Related Overdose Included in Drug Management Programs (DMPs) – p. 9025

CMS proposes to modify the definition of "potential at-risk beneficiary" to include a Part D eligible individual who is identified as having a history of opioid-related overdose or prescription drug events (PDE). While we understand the intent of such a proposal, we cannot support it because of its potential for enormous and destructive unintended consequences. For example, this change could cause individuals not to seek follow up emergency care after they have self-treated with Narcan—or have had Narcan administered by non-medical personnel—because they do not want to be put into the at-risk category. It may also dissuade people from accessing drugs intended to treat substance-use disorder (SUD). If CMS moves forward with this proposal, we urge heightened awareness of these pitfalls, as well as increased monitoring.

CMS proposes to use a 12-month lookback period for a record of opioid-related overdose and a 6-month lookback period for a record of a PDE and identifies past overdose as the most predictive risk factor for another overdose or suicide-related event. We seek clarification as to whether the designation as a potential at-risk beneficiary would be lifted once the enrollee is past the 6- or 12-month period post PDE or overdose. While it is true that a history of overdose is predictive, we do not believe the 6- or 12-month cutoff matches a sharp downturn in the risk.

CMS notes that the proposed 12-month lookback period determination would be based on Medicare FFS claims and MA encounter data. This does not appear to account for people who are new to Medicare who may be younger and transitioning from Medicaid, a Qualified Health Plan, or another commercial plan. Such individuals would be no less at risk than long-term Medicare enrollees. We seek clarification as to how or if these proposals would identify people who were not enrolled in Medicare during the lookback periods.

CMS suggests that providers who are newly aware of a beneficiary's history of overdose should consider prescribing the beneficiary an opioid-reversal agent. We strongly support this suggestion and urge relevant authorities to consider making such prescribing mandatory whenever possible.

D. Beneficiaries' Education on Opioid Risks and Alternative Treatments – p. 9028

CMS suggests allowing plan sponsors to disclose opioid risks and alternate coverage information to all Part D enrollees but identifies as a disadvantage the fact that this would be largely over-inclusive, in the sense that a significant number of enrollees would receive information that is not, and may never be, pertinent to them. Despite this concern, we support the outlined education

plan. A goal of prevention and public health is to ensure that the information has the best chance of getting to the people who need it. In the case of opioids, this could be anyone. Importantly, the lack of a prescription for opioids does not preclude a beneficiary from having used them, due to prescription sharing or other unauthorized use.[2] With respect to the distribution of this and related information, there could also be heightened focus on those who have greater than 7 days of continued opioid use.

F. Automatic Escalation to External Review Under a Medicare Part D Drug Management Program for At-Risk Beneficiaries – p. 9032

We support the Secretary exercising his discretion under the statute to provide for automatic escalation of drug management program appeals to external review. We 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.

IV. Implementation of Certain Provisions of the 21st Century Cures Act – p. 9037

A. Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries – p. 9037

To the extent that CMS seeks to implement changes pursuant to section 17006 of the Cures Act, which removes the prohibition for beneficiaries with ESRD from enrolling in an MA plan, we support the proposed regulatory amendments outlined in the preamble. Although not addressed in the proposed rule, however, we do provide comment on other issues relating to the requirement that MA plans accept people with ESRD starting in 2021, and urge CMS to address these issues.

First, as discussed below in comments (to Service Category Cost Sharing Limits for Medicare Parts A and B Services and per Member per Month Actuarial Equivalence Cost Sharing), CMS must act to ensure that MA plan benefit packages do not discriminate against individuals with ESRD.

Second, CMS must update its educational and outreach materials to reflect the fact that individuals with ESRD can enroll in MA plans starting in 2021. This includes ensuring that dialysis cost-sharing is among the standard services/items reflected on individual plan searches on the Medicare Plan Finder (such information is not currently reflected).

[2] *See, e.g.*, Kebede A Beyene, et al., "Prescription Medication Sharing: A Systematic Review of the Literature," Am J Public Health, 104(4): e15–e26 (April 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4025682/.

V. Enhancements to the Part C and D Programs – p. 9039

E. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System – p. 9043

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 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 organization determination and reconsideration levels of review that may indicate barriers to access care.

The Center appreciates CMS' attention to measures relevant to individuals with disabilities and chronic conditions through the past addition of measures examining care transitions from an inpatient setting to the home, as well as the proposed measure regarding follow-up care provided after an emergency department visit for patients with multiple chronic conditions. In future iterations of the Star Ratings system, the Center recommends 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. The addition of such measures would be a key tool for determining the degree of access to rehabilitation care afforded to MA plan beneficiaries and holding MA plans accountable for ensuring access to these essential services.

F. Permitting a Second, "Preferred", Specialty Tier in Part D – p. 9051

While we appreciate CMS' effort to explore redesigning the Part D benefit structure, we fear that this proposal to permit a second specialty tier will further complicate an already complicated benefit, and may not yield meaningful savings for beneficiaries.

This would not "strike an appropriate balance between plan flexibility and Part D enrollee access to drugs" as CMS states is its intention – instead, this further tilts the scales towards the former, perhaps at the expense of the latter. Later in the preamble, during a discussion of RTBT, CMS notes:

> In our May 2019 final rule (see 84 FR 23832), we cited evidence suggesting that reducing medication cost yields benefits in increased patient medication adherence. Evidence indicated that increased medication out-of-pocket costs was associated with adverse non-medication related outcomes such as additional medical costs, office visits, hospitalizations, and other adverse events. [p. 9060]

We agree with this assessment, and encourage CMS to apply it to this section on specialty tiers. Under this proposal, there would be questionable cost-savings to beneficiaries, including the fact that they would be subject to the same cost-sharing threshold of at least 25% of the costs of very expensive drugs.

We recommend that CMS withdraw this proposal. Instead, we urge CMS to eliminate specialty tiers, or, at the very least, allow tiering exceptions for specialty tier drugs. As CMS notes in the preamble, tiering exceptions are currently not allowed for medications on the specialty tier—despite the fact these are among the highest cost medications, making them unaffordable for many beneficiaries with fixed incomes and limited resources. We strongly support the establishment of a cost-sharing exception and appeal process for drugs included on the specialty tier, both as a matter of fairness and to promote affordable access to high-cost medications. For additional ways to improve beneficiary access to drugs through the Part D benefit, we refer CMS to comments we previously submitted that recommend, among other things, improving the Part D appeals process by requiring individually-tailored notices at the pharmacy counter and mandating that denials at the pharmacy counter trigger the appeals process.[3]

CMS also proposes to raise the dollar threshold for a drug to qualify for the specialty tier from $670 to $780 for 2021. We support this increase. The current pricing structure allows far too many drugs onto the specialty tier, negatively impacting beneficiary access and affordability.

[3] See, e.g., Center for Medicare Advocacy comments to CMS re: "Patients Over Paperwork Initiative" (August 2019), available at: https://www.medicareadvocacy.org/cma-comments-on-patients-over-paperwork/.

G. Beneficiary Real Time Benefit Tool (RTBT) – p. 9059

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. Plans would be able to use existing secure patient portals, develop a new portal, or use a computer application to fulfill this requirement. Plans would be required to also make this information available to enrollees who call the plan's customer service call center.

While we appreciate efforts to provide more information to Medicare beneficiaries, and generally support requiring plans to implement an RTBT, we assert further efforts to provide individuals with such information should be made prior to enrollment in a given Part D plans. For example, the information provided by the RTBT should be incorporated into, or otherwise available via, the Medicare Plan Finder (MPF). The preamble states that the MPF cannot provide beneficiary-specific formulary alternatives for enrollees, nor can it provide beneficiary-specific prior authorization information (including whether, for example, PA has been met by a particular beneficiary for a particular drug). CMS can 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.

CMS notes that "there are not any different standards available for a beneficiary tool" and that a "standard is only required when information flows to another system." Even if CMS requires RTBT to be available only within individual plan sponsor systems rather than interaction with other systems, uniformity and standardized platforms are desired if plans are expected to provide the same type of information, in the same way, so that beneficiaries who do change plans have points of comparison. Standardization would also, it would seem, make it easier for CMS to "monitor improper use" including insuring that such tools are "devoid of commercial purposes that would adversely impact the intended functionality of promoting cost-effective beneficiary and prescriber selection of drugs." P. 9062.

J. Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration and Part D Coverage Determination and Redetermination Requests – p. 9069

We believe that CMS' proposal for regulations that govern withdrawals and dismissals for Part C Organization Determinations, Reconsiderations, and Independent Review Entity (IRE) Reconsiderations will help provide needed clarification to the appeals process. We encourage CMS to consider some additional language to ensure the process is as clear as possible.
Under the new proposed section 422.592(i), if the IRE determines that the Medicare Advantage Plan's (MA Plan) dismissal was in error, the dismissal would be vacated and remanded to the MA Plan for Reconsideration. However, there is no time frame indicated for which the MA Plan

is required to issue a decision on the remanded appeal. To ensure consistent deadlines CMS should specify that the deadlines enumerated in 42 C.F.R. §422.590 apply to remanded appeals. In addition, under proposed sections 422.568(j), 422.631(h), and 422.568(l), dismissals of Organization and Coverage determinations would be binding unless vacated by the MA Plan, applicable integrated plan, or Part D plan sponsor. The proposed regulations should include language allowing for the appeal of the dismissal to subsequent levels of review, including but not limited to Reconsideration, IRE Reconsideration, and Administrative Law Judge review. It would be improper to limit appellants to review only by the MA Plan without the opportunity to appeal the dismissal of an organization or coverage determination to an independent entity.

VI. Codifying Existing Part C and D Program Policy – p. 9072

B. Service Category Cost Sharing Limits for Medicare Parts A and B Services and per Member per Month Actuarial Equivalence Cost Sharing – p. 9077

General Comment

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, serves as a deterrent to obtaining medically necessary care and is simply out of reach, financially, for a large number of beneficiaries. Further, allowing multiple MOOP levels with varying levels of cost-sharing for varying services makes comparing and choosing plans more difficult. From a consumer advocacy perspective, MA plan benefits should be more standardized, not less.

MA Cost-Sharing for Dialysis

We object to the approach CMS is taking concerning MA cost-sharing for dialysis. CMS must act to ensure that MA plan benefit packages do not discriminate against individuals with ESRD. In the preamble, CMS outlines obligations that MA plans have to design benefits in manner that are not discriminatory. On the one hand, §3202 of the Affordable Care Act (ACA) states that cost-sharing under MA plans cannot exceed the cost-sharing imposed under traditional Medicare for three specific services—chemotherapy administration, renal dialysis services, and skilled nursing care. Under Part B of Medicare, the coinsurance rate for dialysis is 20%. On the other hand, federal law contains strong anti-discrimination provisions, including a requirement that "[t]he Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization." 42 U.S. Code § 1395w–22(b)(1). Further, federal regulations require CMS, in its review of approval of MA benefits and associated cost-sharing, to ensure that "MA organizations are not designing benefits to discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services." 42 CFR §422.100(f)(2).

As noted by CMS, "[e]stablishing limits on cost sharing for covered services is an important way to ensure that the cost sharing aspect of a plan design does not discriminate against or discourage enrollment in an MA plan by beneficiaries who have high health care needs." P. 9078.
Yet, with little discussion, in Table 5 on pp. 9086-7, which provides "illustrative cost-sharing limits for contract year 2022", CMS appears to propose to allow MA plans to charge up to 20% coinsurance for dialysis, regardless of an MA plan's MOOP level. Late in 2019, the Center was alerted that a Kaiser Permanente Medicare Advantage plan in Southern California notified enrollees it was increasing coinsurance it charged for dialysis from $0 in 2019 to 20% coinsurance in 2020. By virtue of the current system of MA regulatory oversight, this was a benefit package change that was analyzed and approved by CMS for the 2020 plan year. In other words, this is already happening, with CMS approval.

Imposition of cost-sharing is generally intended, in part, to prevent consumers from over-utilizing health care services. However, dialysis is not a service that is over-utilized by an individual with ESRD. Instead, it is a regular, medically necessary service that is required by a population with a particular diagnosis. Charging maximum cost-sharing permissible under the law for a particular service used by a particular population could be viewed as discriminatory on its face. It would not stretch credulity to wonder if an MA plan charging 20% coinsurance for dialysis – after charging nothing in the previous year – may be an attempt to discourage individuals with ESRD from staying enrolled in the plan. At the very least, absent intent by the plan, such benefit design can be deemed likely to substantially discourage enrollment by people requiring dialysis, and, once the right to enroll in any MA plan is effective in 2021, would force them seek out other plans that do not impose such costs. At worst, if such benefit design becomes the norm in 2021 rather than an outlier, it will be a race to the bottom among MA plans to try to dissuade enrollment by individuals with ESRD, despite new requirements that they must now accept all comers. Even with mandatory out-of-pocket caps that MA plans must employ, charging such a high rate for dialysis will be cost-prohibitive for many individuals with ESRD, and certainly counter-productive to their health should they be unable to afford such ongoing costs prior to the triggering of a MOOP.

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 tolerated.

<u>MA Cost-Sharing for Home Health</u>

CMS proposes to allow MA plans with a lower MOOP to charge up to 20% coinsurance for home health services (for which traditional Medicare charges nothing). We object to this pro-

posal. The application of a MOOP should not be used to justify an MA plan charging cost-sharing for services that that are insulated from any costs in traditional Medicare. CMS should prohibit cost-sharing for home health services in MA plans.

MA Cost-Sharing for DME

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." P. 9084. It is easy to see how cost-sharing applied to certain DME, which is used by individuals with certain conditions, can constitute discriminatory cost-sharing on its face, particularly without additional guidance from CMS about what types of items can be subject to higher rates. We urge CMS, at the very least, to require uniformity with respect to cost-sharing for DME.

C. Plan Crosswalks for Medicare Advantage (MA) Plans and Cost Plans – p. 9088

Comments on Crosswalk Proposals

CMS proposes to codify the current process and conditions under which MA organizations and cost plans can transfer enrollees into the same plan or plan type from year to year when no other election has been made ("plan crosswalk") as well as when plans can transfer enrollees to other plans of a different type offered by the same organization ("crosswalk exception").

With respect to cost plans, in §417.496(c)(1)(iii)(A), (B), and (C), CMS proposes to codify that an enrollee in a terminating PBP that includes Part D may only be moved to a PBP that does not include Part D if the enrollee is notified in writing that she/he is losing Part D coverage, the options for obtaining Part D, and the implications of not getting Part D through some other means. Based on our experience, this is simply not enough protection to ensure that an individual has ongoing Part D coverage. We too often hear from individuals who do not receive important notices from their plans, or have such notices lost in the barrage of advertising and other materials mailed during the annual enrollment period. Instead, CMS should require that an individual in this situation actively opt-out of Part D coverage, in writing, in order to allow being moved into a plan without such coverage.

With respect to Medicare Advantage plans, in §422.530(a)(2), CMS proposes to codify the general rule that crosswalks are prohibited between different MA contracts or different plan types (for example, HMO to PPO). This means that crosswalks are only permitted between plans of the same type under the same contract. We support the general prohibition of crosswalks between different plan types and between different contracts 422.530(a)(2), but assert that exceptions at section (c) are too permissive.

CMS is specifically proposing to restrict crosswalks between network PFFS and non-network PFFS plans because the way enrollees will access health care services is significantly different in

each of these plans. We support such restriction, but suggest CMS prohibit such crosswalks altogether.

General Comments re: MA Enrollee Protections

More broadly, we urge CMS to examine the impact of crosswalks on plan enrollees. The only time either the new regulation or the preamble reference the interests of beneficiaries in relation to crosswalking is with respect to contemplated crosswalks between network on non-network PFFS plans. In such a scenario, "CMS will consider whether the risks to enrollees are such that they would be better served by remaining in the plan, whether there are other suitable managed care plans available, and whether the enrollees are particularly medically vulnerable, such as institutionalized enrollees." P. 9091.

On the one hand, we recognize that the current Medicare Advantage (MA) and Part D landscape in Medicare allows plans sponsors to choose to contract with Medicare on an annual basis, and allows such plans to alter their benefits and cost-sharing year to year. On the other hand, in order to ensure that Medicare beneficiaries are obtaining the best coverage for the best value, they are expected to make annual re-assessments of their coverage and compare available options, although most do not do so. The landscape is increasingly becoming one in which only the savviest consumer is able to make a fully informed choice about their individual, optimal coverage options.

An MA enrollee's rights and protections are significantly different when a plan sponsor makes a business decision to stop offering a plan altogether (or reduce a service area) versus moving enrollees from one contract to another (crosswalking), which may include discontinuing one or more plan contracts. In the former scenario, MA enrollees are afforded special enrollment period (SEP) rights and Medigap guarantee issue rights. In the latter scenario, movement from one plan to another is permitted as long as the new plan retains the same corporate logo.

In other situations, MA enrollees have even more rights. The Medicare Managed Care Manual, Ch. 2, Sec. 20.4.2 outlines situations in which CMS passively enrolls individuals into another MA plan. This occurs in certain instances, including immediate plan terminations or situations in which remaining in the plan would pose potential harm to the members. In assessing an individual beneficiary's welfare, CMS evaluates the receiving plan using key criteria, including: similar or lower out-of-pocket maximum, similar or lower hospital cost-sharing amount, no additional network restrictions, premium isn't significantly higher, and equivalent or higher value Part D benefit and formulary structure. Thus, when passively enrolling an individual into another plan, CMS is required to evaluate the comparable benefits between a current and receiving plan, and ensure that the plans are more or less comparable. This requirement should be more broadly required.

When an MA plan sponsor proposes to crosswalk current enrollees into another plan offered by the same sponsor, we urge CMS to require plan sponsors to attest that the plan into which enrollees are crosswalked offers comparable benefits to the plan they are being moved from. Otherwise, CMS should not approve the crosswalk exception request.

More broadly, it is time to revisit and strengthen consumer protections in MA and Part D. While certain information about plan changes from year to year is provided in a plan's Annual Notice of Change (ANOC) document, this leaves enrollees to parse whether and how their plan will change. Most people who are enrolled in a given plan tend to rely on that plan remaining more or less the same, and, as a consequence, many people do not carefully scrutinize the ANOC. Such individuals should not be penalized if their plan benefits change significantly from one year to another. Plan sponsors rely on brand loyalty and beneficiary inertia in order to retain enrollees. If a plan substantially changes it benefits to an enrollee's detriment, at the very least such an individual should get the same SEP right as is provided for plan non-renewals or terminations. When a plan significantly changes it benefits, it is almost like offering a new, different plan with the same logo; why should this scenario be different from a non-renewal or termination?

E. Medicare Advantage (MA) and Cost Plan Network Adequacy – p. 9092

Comments re: CMS Proposals

CMS proposes to codify network adequacy methodology for MA plans, and proposes new policies for rural areas and to encourage the use of telehealth in all areas. We generally object to CMS' proposals regarding network adequacy outlined in the proposed rule. MA network adequacy standards should be strengthened, not diluted.

In the preamble, CMS reveals a likely motive for diluting such rules: "CMS has also received comments concerning patterns of provider consolidation and its impact on higher costs for patients. CMS has heard from stakeholders that providers in concentrated areas may leverage network adequacy requirements in order to negotiate prices well above Medicare FFS rates." P. 9099. In other words, based on insurance industry complaints, CMS will bend existing rules in order to accommodate plan sponsors and aid in their negotiation with providers. Important consumer protections, such as network adequacy standards, should not be bargained away in order to assist industry pecuniary interests.

In rural areas, CMS is proposing to reduce the required percentage of beneficiaries that must reside within the maximum time and distance standards from 90% to 85%. We object to this proposal. 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. Offering an MA plan with too few providers, too far away, who are reasonably accessible to too few enrollees does not serve a rural population well.

CMS' proposal to codify the list of provider and facility specialty types subject to network adequacy reviews does not include post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs). The Center urges CMS to include IRFs in the facility specialty types as part its network adequacy reviews. A wide range of rehabilitation provider types will help ensure that enrollees have access to the appropriate intensity and scope of needed rehabilitation services. For instance, too often enrollees across the country are diverted into nursing homes rather than IRFs because their health plans do not contract with a sufficient number of these providers. Too often, enrollees with brain injuries, spinal cord injuries, those who have suffered strokes, and others with a variety of complex but common conditions do not receive the intensive longer-term services they need because health plans do not contract with specialized brain treatment programs.

CMS proposes that MA plans 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. The Center objects to this proposal, and urges CMS not to adopt it. Further, if CMS chooses to adopt it, we urge CMS not to expand this credit to other specialty provider types.

The current COVID-19 crisis has made the importance of access to telehealth more apparent, particularly when there are significant restrictions on the ability of beneficiaries and providers to interact with one another. While the Center generally supports exploring ways to increase access to care through the use of telehealth, such access should not come at the expense of providing quality care to enrollees. As CMS notes in the preamble, in response to previous rulemaking, providers had more concerns than health plans "that telehealth services could be used to replace in-person healthcare delivery." P. 9098. Although CMS notes it is not proposing to make any changes to how minimum provider requirements are calculated, giving a 10-percentage point credit to plans nonetheless dilutes access to care by allowing plans to provide less than adequate access to a greater percentage of their enrollees. As noted by CMS, "our data indicates that existing failures in MA plans' meeting the time and distance standards frequently occur at the range between 80-89 percent of beneficiaries." P. 9089. Again, 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. Existing rules should not be diluted in order to enable more plans to meet such rules; network adequacy should not be graded on a curve.

<u>General Comments re: MA Network Adequacy</u>

As CMS is aware, in 2015 the General Accounting Office (GAO) released a report entitled "Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy".[4] GAO examined several factors relating to CMS' oversight of MA organization (MAO)

[4] Available at: https://www.gao.gov/products/GAO-15-710

network adequacy, and made corresponding findings, including: how CMS defines network adequacy and how its criteria compares with other programs; how and when CMS applies its network adequacy criteria; the extent to which CMS conducts ongoing monitoring of MA organization networks; and how CMS ensures that MA organizations inform beneficiaries about terminations.

As noted in previous comments to CMS[5], the Center acknowledges that while CMS has made efforts to address some of the deficiencies highlighted by GAO, so far such efforts appear to be primarily directed at provider directories alone (discussed below). CMS noted in the draft 2016 Call Letter that "[t]he data collected through our monitoring activities could drive additional reviews of network adequacy, as well as future monitoring and/or audit-based activities" [emphasis added]. We continue to urge CMS to more broadly expand its oversight and definition of network adequacy, as suggested by GAO.

In addition, in order to ensure that MA plan enrollees have adequate access to plan providers, we urge CMS to further address both provider directories and mid-year network provider terminations, discussed, in turn, below.

In 2017, CMS announced the agency's findings from a review of 54 MA organizations, showing widespread inaccuracies in MA provider directories.[6] In response, the agency released additional guidance reiterating the rules MA organizations must follow for provider directories and took appropriate compliance actions. The draft 2020 Call Letter noted that "there has been a lack of improvement in the accuracy of provider directories over the past three years." Directory inaccuracies can present significant challenges for enrollees—up to and including a potential lack of access to care and significant out of pocket costs. We urge CMS to focus its attention on the undue burden that inaccurate, hard-to-access, and non-searchable provider directories place on beneficiaries.

Similarly, we remain disappointed that CMS has taken no further action, either in Call Letters or in rulemaking, to strengthen consumer protections surrounding MA plan mid-year provider network terminations. The most effective way to protect consumers from being trapped in their plans after their own doctors are involuntarily terminated is to prohibit MA plans from terminating network providers mid-year without cause. Not only did CMS retreat from this option in the final 2015 Call Letter, but there has been no attempt to extend the current 30-day advance notice to affected beneficiaries, as also suggested in the 2015's Draft Call Letter. Further, CMS has failed to strengthen or otherwise expand the limited special enrollment period (SEP) right available only to beneficiaries affected by "significant" network terminations. In addition, the availa-

[5] See, e.g., Center for Medicare Advocacy comments to the 2020 Draft Call Letter (March 1, 2019), available at: https://www.medicareadvocacy.org/center-comments-on-2020-medicare-parts-c-d-call-letter/.
[6] CMS, "Online Provider Directory Review Report" (January 2017), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf.

bility of this limited SEP right is not adequately expressed in beneficiary-oriented materials, including those issued by plan sponsors (e.g. the Annual Notice of Change) or by CMS (e.g. Medicare & You and the www.medicare.gov website). More accurate provider directories, while a welcome improvement in consumer information, is not a solution to this problem. As addressed below in the section regarding SEPs, we urge CMS to expand such rights.

H. Requirements for Medicare Communications and Marketing – p. 9108

Overview

CMS proposes to codify sub-regulatory guidance contained in the existing Medicare Communications & Marketing Guidelines (MCMG). The Center has significant concerns about the substantive changes CMS made to the MCMG in 2019 and the manner in which it was done. CMS rescinded important consumer protections from the final 2020 marketing guidelines, without any public comment, resulting in watered down standards that are now being codified pursuant to CMS' interpretation of the decision in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).

In August 2019, the Center joined the Medicare Rights Center, Justice in Aging and the National Council on Aging in sending a letter to CMS Administrator Verma expressing concerns about revisions to marketing guidelines and the roll out of the updated Medicare Plan Finder (hereinafter referred to as "joint letter").[7] As noted in the letter, the MCMG is intended to provide "adequate protections against inappropriate marketing practices" but that the "2020 guidance falls woefully short [of such goal], making changes that appear to primarily act to ease the burden on plans and downstream entities while at best doing little to benefit or protect consumers and at worst increasing the likelihood consumers will experience harm."

The joint letter outlines concerns with the manner in which CMS revised the MCMG:

> [W]e also object to the process by which CMS is ushering in the 2020 guidance. While we appreciated the opportunity to provide feedback on the draft 2020 Medicare Communications and Marketing Guidelines (MCMG), we were troubled that unlike in previous years, CMS did not subsequently release a final 2020 version of that guidance. Instead, the agency broke with its longstanding practice and issued an HPMS memo that lists changes from the 2019 guidance and tells plans that for 2020, they should rely on the 2019 guidance as amended by the memo. This approach, which is a significant step backward in clarity and transparency, is all the more confounding since CMS already created and distributed a redlined draft of the 2020 MCMG for comment.

[7] The letter (dated August 27, 2019) is available here: https://www.medicareadvocacy.org/joint-letter-concerning-medicare-plan-finder-and-marketing-materials/.

> It also is concerning that the final guidance veers significantly from this draft. Instead of adding some helpful clarifications and tightening of guidance that had appeared in the draft, the final product took a sharp U-turn. Not only were most of the additions that would have been protective of beneficiaries abandoned, important existing provisions were summarily dropped without warning or an opportunity to comment, and new provisions that either did not appear or were not flagged in the draft version were finalized, effectively disregarding the process for stakeholder input.

In the NPRM, CMS states: "[t]o be clear, the policies we are proposing to codify are not new to the industry; they are already in place in the MCMG and were developed over time in concurrence with industry comments weighing in on the best way to implement marketing requirements in the context of operating the MA, Part D, and cost programs, and plans are accustomed to conforming to these policies." P. 9109. This statement is only true if it excludes the revisions made to the 2020 MCMG.

As discussed further below, of particular concern are the substantive changes introduced in the guidance for the 2020 plan year, like the blurring between marketing and education, the removal of non-English translation disclaimers, and ongoing lack of information regarding MA special supplemental benefits for the chronically ill (SSBCI). While CMS has reinstated some consumer protections it stripped from the MCMG, it has neglected to address others. We ask that these consumer protections be reinstated or otherwise included in the final regulations.

Marketing v. Communications

Although, as noted in the preamble, CMS has already incorporated the definitions of "marketing" and "communications" in regulation and sub-regulatory guidance, we again offer our objection to how documents are classified for review.

Our comments to CMS regarding (what we believed to be) the draft 2020 MCMG,[8] we stated:

> We recognize that regulations have redefined how communications and marketing documents are classified for purposes of CMS review. As noted in our comments to last year's draft MCMG, we disagree, though, with CMS' assertion that documents which may impact an enrollment decision, but are not intended to do so, don't qualify as marketing documents. If a beneficiary uses a plan-issued document to make enrollment choices, the sponsor's intent is irrelevant. Plan- and agent/broker-issued content should be subject to stringent oversight by CMS to ensure accuracy and readability.

[8] Center for Medicare Advocacy comments to CMS on MCMG (April 2019) available at: https://www.medicareadvocacy.org/center-comments-on-medicare-marketing-guidelines/.

In its description of which documents are considered marketing or communication materials, CMS indicates that among others, the formulary, pharmacy directory, provider directory, low income subsidy (LIS) premium subsidy and rider, mid-year change notification to enrollees, and the Part D transition letter are all communications documents. We believe these are all documents which may not have the intent of impacting enrollment, but indeed can have a strong impact on enrollment decisions, and thus deserve classification as marketing materials. For example, a beneficiary may use the formulary and directories to understand if their drugs, doctors, and pharmacies are covered and make a change in plan enrollment accordingly. At a minimum, CMS should consider establishing a separate pre-release review process for these documents, given their importance for beneficiaries.

In cases where CMS identifies inaccuracies or misleading information through a post-release review, we strongly urge CMS to allow affected beneficiaries to have a special enrollment period, in order to mitigate consequences of decisions based on inaccurate or misleading information.

Marketing v. Educational Events

In this section, we outline our original objections to the 2020 revisions to the MCMG provisions concerning the difference between marketing and educational events, including time and place distinctions, as well as CMS' utter failure to address this issue in the current proposed rule.

2020 MCMG Revisions

Here we quote at length from our joint letter, in which our organizations presented objections to the manner in which these provisions were revised, including the apparent conflict with federal law:

Regarding the content, troublingly, the revised guidelines weaken the distinction between "marketing" events, which are designed to steer or attempt to steer potential enrollees, or the retention of current enrollees, toward a plan or limited set of plans; and "educational" events, which are designed to inform beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs.

Such changes appear to directly conflict with current law. Section 103 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) prohibits "Sales and marketing activities for the enrollment of individuals in Medicare Advantage [and Part D plans] plans that are conducted" at educational events; similarly, 42 C.F.R. §§ 422.2268 and 423.2268(b)(8) state that "in marketing" MA and Part D plans, sponsors may not "Conduct sales presentations or distribute and accept plan applications at educational events."

The new MCMG revisions are inconsistent with these requirements. For example, they eliminate the current requirement regarding unsolicited contacts that restricts when an agent or broker can contact someone by removing the following language from the 2019

guidelines: "If a potential enrollee provides permission to be contacted, the contact must be event-specific, and may not be treated as open-ended permission for future contacts."

Further, the revised guidance removes language requiring marketing appointments generated from an educational event to be distinct in time and place; the revisions delete "future" from the current language, which now reads that agents or brokers "May set up a future marketing appointment, and distribute business cards and contact information for beneficiaries to initiate contact (this includes completing and collecting a Scope of Appointment (SOA) form)." And the subsequent requirement—that an agent or broker "[m]ay not conduct a marketing/sales event immediately following an educational event in the same general location (e.g., same hotel)" is eliminated entirely.

In sum, the updated guidance seemingly allows educational events (which have fewer restrictions and no reporting requirements to CMS) to immediately turn into marketing events. While the guidelines still note that educational events "[m]ust not include marketing or sales activities or distribution of marketing materials or enrollment forms," it appears that an agent or broker could immediately step out of the room, so to speak, and conduct a sales event. This defeats the purpose of delineating these types of events, and likely violates both the spirit of MIPPA and its implementing regulations.

The Center also addressed these changes in a subsequent Weekly Alert,[9] in which we highlighted the response by agents and brokers to these changes:

These changes will be a boon for health plans and the contracted entities selling their products. As noted in an *AIS Health* article, these revisions "contain multiple flexibilities that were previously unavailable to plan sponsors" and, according to one industry consultant, "'The deletions are more important than the insertions […] Probably the most important deletion concerns the prohibition on holding back-to-back educational and marketing events. This seems to open the door to piggybacking marketing sessions on educational events.'"

Similarly, a posting on the "Agent Survival Guide", published by an insurance marketing firm, notes that the changes, among other things, mean that "the same permission to contact can be used across different election periods […] (CMS) has never allowed this practice before, so it opens the door to more extended permission to contact Medicare eligibles you've had prior relationship with." In addition, the combination of other changes "seems to suggest that agents are allowed to collect [Scope of Appointment forms] and take applications at the end of an educational event, which was previously prohibited. Therefore, if an agent feels it's in his/her and their clients' best interest to hold the two events back to back, they are permitted to do so."

[9] Center for Medicare Advocacy Weekly Alert "Advocates Issue Joint Letter Raising Alarms about New Medicare Plan Finder and Revisions to MA and Part D Marketing Guidelines" (August 29, 2019), available at: https://www.medicareadvocacy.org/advocates-issue-joint-letter-raising-alarms-about-new-medicare-plan-finder-and-revisions-to-ma-and-part-d-marketing-guidelines/.

The distinction between educational and marketing events was created, in part, so that beneficiaries would not be pressured to enroll in an MA or Part D plan during an educational event. While the distant time and location requirements separating these two types of events might inconvenience an agent/broker who wishes to sell a product to a prospect who appears interested immediately following an educational event, this changes the tenor and dynamic of educational events. Presumably individuals show up for educational events because they are advertised as such; if they were interested in engaging in a possible sale they have opportunities to do so, whether it is through an advertised marketing session, through an individual agent/broker, or directly through a plan. If agents/brokers can immediately make a sale after an educational event, it turns such events that were designed to be without pressure into a hunting opportunity for agents/brokers or plan representatives. The previous requirements mandating that any marketing events occur distant in both time and place allowed a cooling off period for beneficiaries between an event where they came to learn and one in which they are being pressured to buy something. Now that this distinction is blurred, the same disclosures and reporting requirements that apply to marketing events should apply to educational events.

Current Proposed Rule

In the NPRM, CMS fails to address what had previously been a clear statutorily required distinction between marketing and educational events, including differences in time and place.

CMS' entire discussion of this issue in the preamble is limited to the following: "Finally, in §§ 422.2264(c) and 423.2264(c), we propose to codify requirements regarding events (such as meetings) with beneficiaries, currently found in section 50 of the MCMG; in doing so, we include some additional statements consistent with our current policies of what plans may do." P. 9110. Similar to the lack of explanation for this revision in the 2020 MCMG, there is no discussion of this significant revision in the NPRM. To our knowledge, there has been no public statement by CMS or discussion concerning this issue.

Absent any clarification in the preamble, we turn to the proposed regulatory language itself. Proposed section 422.2264, entitled "Beneficiary contact" addresses "Events with beneficiaries in subsection (c) at p. 9230. After noting in (c)(2) that "Marketing or sales events are group events that fall within the definition of marketing at § 422.2260", subsection (i) states the following:

> (i) If a marketing event directly follows an educational event, the MA organization or agent/broker must provide an opportunity for beneficiaries to determine if they want to continue onto the marketing event.

This language is provided with no additional explanation – either in the preamble or the regulatory text. Vague beyond any usefulness, this language apparently leaves it entirely to the agent/broker to determine if consent is given by the beneficiary "to continue onto the marketing

event." Can this meager requirement be satisfied if an agent/broker says "so would you like to talk more about [Plan X]?" or "Shall we?" or merely if the beneficiary fails to verbally object?

We are further puzzled that certain other protections that were removed from the 2020 MCMG, such as D-SNP look alike and non-English language disclaimers, were added back in via the NPRM, whereas the removed provisions requiring time and place distinctions between marketing and educational events remain absent, without explanation.

Again, these revisions appear to violate MIPPA. CMS has an obligation to explain how these revisions do not violate MIPPA. Further, since this was done without public comment, we ask CMS to disclose from whom they received requests to make these changes, and, if no such requests were made, why the agency did this. We strenuously object to this change, and urge CMS to reverse this end-run around the MIPPA provisions mandating a distinction between marketing and educational events.

<u>Non-English Translation Disclaimer & 1557 Compliance</u>

Our joint letter noted:

> Also of concern is the removal of several disclaimers in Appendix 2 without explanation, including the one governing the "Availability of Non-English Translations." This disclaimer is short and had only been required on a subset of communications that are subject to translation requirements pursuant to 42 CFR 422.2268(a)(7) and 42 CFR 423.2267(a)(7). Except for a handful of small markets, the disclaimer was only required in one language, Spanish. In the 2019 MCMG, CMS harmonized the wording of the disclaimer with the wording required by Section 1557 regulations to ensure that this requirement would place no additional burden on plans.
>
> We are at a loss to understand the rationale for removing this simple requirement to place at most two lines of text in Spanish on important documents so that Spanish speakers will know the availability of assistance. The burden on plans is miniscule and the need to alert limited-English proficient beneficiaries that they can receive help is great. Beneficiaries must be made aware that interpreter services and translated materials are available, if this assistance is to be effective.

We note that the NPRM re-incorporates instructions to plans regarding disclaimers concerning the availability of non-English translations on materials and content at proposed §422.2267(e)(32). We are pleased that this provision was added back in, but are puzzled as to why it was removed for the 2020 plan year, without explanation. We urge CMS to further remind plans about their obligations to comply with Section 1557 notice requirements, including "taglines" or disclaimers in the top 15 languages and to conduct enforcement and oversight when appropriate. We note that here is a growing need for stronger translation requirements.

D-SNP Marketing

As noted in the joint letter:

> The draft of the 2020 guidance circulated earlier this year for stakeholder comment included new language intended to ensure more accurate and transparent marketing of Medicare Advantage plans to dual eligibles that are not Duals-Special Needs Plans (known as D-SNP look-alikes) […] It is therefore confounding that the final memo failed to include the changes outlined in the draft that would have acted to limit the aggressive marketing of these look alike products to duals.

Unlike consumer protections that were rescinded without notice, as discussed above, the draft 2020 MCMG actually did include language about D-SNP look-alike plans that was supported by consumer advocates, yet did not appear in the final version. We appreciate their inclusion in the NPRM. We support the proposed requirement that the summary of benefits must include Medicaid benefits for D-SNPs and the prohibition on MA plans marketing non-D-SNPs as if they were designed for dual eligibles or claiming that they have a relationship with the state Medicaid agency.

We urge CMS to take further action to protect dual eligibles from marketing misconduct. This includes a need for clear requirements when an agent/broker is disenrolling a dual eligible out of an integrated product (D-SNP or MMP) to explain to the individual what s/he is disenrolling from and that s/he will be in a non-integrated product and what that means for their care. The same requirements should exist for the outbound enrollment verification call, and CMS should require actual contact with the consumer during the call. Further, CMS should discourage or prohibit D-SNP marketing except only to those enrolled in an affiliated Medicaid plan.

Lack of Information Regarding MA Supplemental Benefits

We are troubled not only with what has been removed from the MCMG, but what CMS has failed to include. Since CMS relaxed rules governing MA uniformity requirements and Congress allowed plans to offer special supplemental benefits for the chronically ill (SSBCI), the Center and other consumer advocates have urged CMS to issue guidance concerning the marketing of such benefits.[10] We remain disappointed that CMS continues to neglect this issue.

Our joint letter stated:

> We also continue to be disappointed that this guidance fails to sufficiently address the marketing of MA plans with new supplemental benefits. Clarity on this issue is much needed, given the potential for this expanded authority to create incentives for sponsors to inappropriately steer or target potential enrollees. In failing to update the marketing

[10] See, e.g., Center for Medicare Advocacy comments to CMS on MCMG (April 2019) available at: https://www.medicareadvocacy.org/center-comments-on-medicare-marketing-guidelines/.

guidelines to forcefully prohibit these practices, CMS is losing an important opportunity to protect people with Medicare.

The availability of supplemental benefits must not become merely or primarily a sales tool and sponsors must not be permitted to use supplemental benefits as a marketing device to persuade beneficiaries into their plans. We are especially concerned that agents and brokers may ask individuals about their health status and use that information to steer them toward specific plans in violation of anti-discrimination rules. And this guidance continues to do nothing to assuage our concerns. CMS must not enable discriminatory practices through lax oversight.

We urge CMS to establish strict rules against such targeting and suggest that all shareable information about every plan be made available to potential enrollees, empowering them to choose the most appropriate coverage for their unique circumstances. In addition, the roll out of these new benefits must be closely monitored, as even the most thoughtful of policies can have unintended effects. To that end, both CMS and plan sponsors must be vigilant in watching for unusual spikes in enrollment, as well as other patterns that might indicate the existence of inappropriate outreach behavior. Such practices must be reported and corrected when identified.

Additional Protections Removed from 2020 MCMG

The Center's Weekly Alert referenced above also catalogued some of the other changes that were made to the MCMG without public comment.[11] Our Alert stated:

> Other revisions to the MCMG, not discussed in the joint letter, include the following, almost all of which seem designed to ease any burden on plans and downstream entities, with little to no benefit or protection for consumers. In some cases, the changes appear to actively weaken protections. Further rolling back of restrictions on plans include:
>
> - 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" in order to allow CMS to review "associated marketing materials" (some plans "co-brand" with providers, pharmacies and other entities);
> - 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). Plans/Part D sponsors must clearly disclose their service area in the marketing materials";

[11] Center for Medicare Advocacy Weekly Alert "Advocates Issue Joint Letter Raising Alarms about New Medicare Plan Finder and Revisions to MA and Part D Marketing Guidelines" (August 29, 2019), available at: https://www.medicareadvocacy.org/advocates-issue-joint-letter-raising-alarms-about-new-medicare-plan-finder-and-revisions-to-ma-and-part-d-marketing-guidelines/.

- Elimination of the requirement that plans must support any comparisons with other plans "by studies or statistical data" – but comparisons must still be factually based and "not misleading";
- Elimination of the requirement that plans use CMS standard icons when marketing a plan's star rating: previously plans were "not permitted to create their own gold star icon or any other icon of distinction." Under the revision, "Plans may create their own gold star icon (or any other icon of distinction) so long as the icon is not misleading or confusing to beneficiaries." (Note: it is unclear how CMS will determine whether or not plan-chosen icons – rather than standardized CMS ones – will be misleading or confusing);
- Elimination of restrictions regarding marketing of plan rewards and incentive programs (such programs provide rewards and/or incentives to enrollees in connection with participation in activities that focus on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources): marketing information from plans no longer must "Be provided in conjunction with information about plan benefits", no longer must "Include information about all rewards and incentives programs offered by the MA Plan, and are not limited to a specific program, or a specific reward or incentive within a program." (Note: this means plans can market such programs independently, without context of overall plan benefits to allow individuals to do cost-benefit analyses regarding whether such incentives are worth it; it is unclear if this can be used to target individuals based upon their health condition);
- Elimination of certain restrictions applicable to provider-initiated activities (those conducted by a healthcare professional, including pharmacists, at the request of the patient or as a matter of a course of treatment, when meeting with the patient as part of the professional relationship between healthcare provider and patient): additional language has been added making it even more clear that such activities are not "marketing," and therefore not subject to regulation by CMS; and
- Elimination of requirement that certain disclaimers (in addition to the Non-English translation disclaimer discussed above) be included in plan materials, including the removal of a "benefits disclaimer" that previously required specific text on marketing pieces listing 10 benefits or more. Eliminated Text: "This information is not a complete description of benefits. Call [insert customer service phone number/TTY] for more information."

<u>Conclusion</u>

Through revisions made to the 2020 MCMG without public comment, combined with what is and is not included in this NPRM, CMS has failed to adequately protect Medicare beneficiaries in an effort to roll back plan sponsor "burden". While CMS intends "for the proposed regulations to closely mirror" the "long-standing sub-regulatory guidance" in the form of the MCMG, CMS gutted such long-standing guidance, presumably at the bidding of those selling MA and Part D products, so that the version that is codified is more to their liking.

We urge CMS to revamp the new proposed marketing regulations by, among other things, re-incorporating provisions that were removed from the 2020 MCMG and adding additional provisions, including guidance for marketing of MA SSBCI.

M. Special Election Periods (SEPs) for Exceptional Conditions – p. 9116

CMS proposes to codify a number of Special Election Periods (SEPs) that it has adopted and implemented through sub-regulatory guidance as exceptional circumstances SEPs, which it believes will provide transparency and stability for stakeholders about the MA and Part D programs and about the nature and scope of these SEPs by ensuring that the SEPs are changed only through additional rulemaking.

While we are encouraged by both the intent to primarily keep existing SEPs in place, as well as retention of the ability for CMS to grant case-by-case exceptional circumstance SEPs, we are concerned that leaving the creation of new SEPs solely to rulemaking will mean that it will take longer to implement new, necessary SEPs should the need arise. Creating new SEPs only through rulemaking will make the agency's response less nimble and may hinder its ability to quickly meet the needs of beneficiaries. While CMS can grant case-by-case exceptional circumstance SEPs, there may systemic issues that emerge that require broad-based relief to be implemented prior to the standard notice and comment rulemaking schedule. We hope that CMS will not be deterred in, for example, providing for sub-regulatory, broad-based relief by creating needed SEP rights that are advertised to beneficiaries, plan sponsors, and 1-800-MEDICARE customer service representatives.

We strongly support CMS' statement that it retains the ability to grant case-by-case exceptional circumstance SEPs, and that the list at §422.62(b)(26) is not exhaustive. We urge CMS to reiterate, or otherwise educate, plan sponsors, 1-800-MEDICARE counselors and CMS staff that despite exceptional circumstance SEPs now being codified, that such discretion still exits.

CMS proposes two SEPs that do not currently exist in guidance: the SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer and the SEP for Individuals Enrolled in a Plan Placed in Receivership. We support the addition of these new SEPs and assert that they will strengthen current consumer protections.

CMS seeks comment on whether there are other exceptional circumstances it has not identified for which it should consider establishing an SEP. First, we urge CMS to articulate in regulatory language (either in the SEP for individuals affected by a federal employee error or a separate entry) that an SEP for exceptional circumstances may exist for individuals who rely, on their detriment, on errors in the Medicare Plan Finder (MPF) or other CMS-issued or managed information platforms. Following roll-out of new MPF in the fall of 2019 and documented errors on the

site[12], CMS has acknowledged that an SEP for exceptional circumstances is available when individuals rely upon such misinformation when making a plan choice. For a time period covering late 2019 and early 2020, Medicare.gov website page describing an SEP for exceptional circumstances[13] included the following language, which has since been removed:

> *Note: If you believe you made the wrong plan choice because of inaccurate or misleading information, including using Plan Finder, call 1-800-MEDICARE and explain your situation. Call center representatives can help you throughout the year with options for making changes.*

Similarly, CMS acknowledged this right in a November 27, 2019 blog post[14]: "[o]f course we want to ensure that beneficiaries are confident in their decisions and happy with the coverage they choose… we've always had a Special Enrollment Period for people who think they made a wrong choice due to inaccurate information." Since CMS is relying more upon codified language to articulate rights that beneficiaries have, such language should appear in the regulations.

Second, while there is an existing SEP for significant change in an MA provider network, it is only triggered when a threshold of terminations is met. As CMS notes in the preamble, "CMS considers significant changes to provider networks to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations and affect, or have the potential to affect, a large number of the MAO's enrollees." P. 9119. We urge CMS to revise this SEP so that it may be used when an individual plan enrollee's provider is terminated without cause. While more limited provider terminations may "occur during the routine course of plan operations", it matters not to an individual if there are a specific number of other enrollees affected by a threshold number of provider terminations. That individual may have joined that plan specifically because their provider contracts with it, or have developed a relationship with that provider they wish to maintain.

Third, we are aware that CMS has revised SEP rights available to individuals dually eligible for Medicare and Medicaid, Medicare Savings Programs (MSPs) and the Part D low income subsidy (LIS). Such right is now only available once per calendar quarter for the first nine months of the

[12] See, e.g., Center for Medicare Advocacy statement "CMS Not Acknowledging Medicare Plan Finder Problems Could Hurt Beneficiaries – Full Statement" (Dec. 2, 2019), available at: https://www.medicareadvocacy.org/cms-not-acknowledging-medicare-plan-finder-problems-could-hurt-beneficiaries-full-statement/

[13] See Medicare.gov website at: https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances-special-enrollment-periods (site visited April 5, 2020).

[14] CMS blog post "We're Heading into the Last Week of Medicare Open Enrollment, Don't Miss Out on Your Chance to Find Better Coverage" (Nov. 27, 2019), available at: https://www.cms.gov/blog/were-heading-last-week-medicare-open-enrollment-dont-miss-out-your-chance-find-better-coverage.

calendar year. For the reasons articulated in our comments to the 2018 proposed rule implementing these changes[15], we urge to reverse this change and reinstate open enrollment for these individuals.

Finally, we urge CMS to establish an SEP right for individuals in MA and Part D plans who are impacted by significant changes in their plan benefits from one year to the next, e.g. significantly higher premiums or reduced benefits. This is particularly important for individuals with standalone PDPs since they do not have the same option to change plans during the first three months of the year afforded to those who begin the year enrolled in an MA plan (pursuant to the MA-OEP).

Changes experienced by enrollees of Humana Part D plans between 2019 and 2020 are illustrative. In a "first look" at 2020 Part D plan offerings, the Kaiser Family Foundation[16] highlighted changes to offerings made by Humana in the context of Part D enrollees who would be paying more or less in premiums if they did not change plans:

> Two-thirds of Part D enrollees without low-income subsidies (9.0 million enrollees) will see their monthly premium increase in 2020 if they stay in their same plan, while one-third (4.3 million) face premium decreases. As an example, the 1.9 million enrollees without low-income subsidies in the Humana Walmart Rx Plan, the third most popular PDP in 2019, will see their monthly premium double in 2020, from $28 to $57, unless they switch plans. This is due to plan changes and consolidations, with Humana consolidating two of its PDPs (Humana Walmart Rx and Humana Enhanced) into one PDP for 2020 and renaming it Humana Premier Rx, with a $57 monthly premium.

As noted above in comments to plan crosswalking, we note that most people who are enrolled in a given plan tend to rely on that plan remaining more or less the same, and, as a consequence, many people do not carefully scrutinize their ANOC or other plan documents describing annual changes. Such individuals should not be penalized if their plan benefits change significantly from one year to another. If a plan substantially changes it benefits to an enrollee's detriment, at the very least such an individual should get the same SEP right as is provided for plan non-renewals or terminations.

[15] Center for Medicare Advocacy comments to 2018 Proposed C&D rule (January 2018) available at: https://www.medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/.

[16] Kaiser Family Foundation "Medicare Part D: A First Look at Prescription Drug Plans in 2020" (Nov. 2019), available at: https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-prescription-drug-plans-in-2020/.

Conclusion

We appreciate the opportunity to submit these comments. For additional information, please contact David Lipschutz, Senior Policy Attorney, dlipschutz@MedicareAdvocacy.org or Kata Kertesz, Policy Attorney, kkertesz@MedicareAdvocacy.org, both at 202-293-5760.

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