Jan. 5, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4205-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program (CMS 4205-P)

The New York Legal Assistance Group (NYLAG) submits this comment in support of the above-named proposed rule published by the Department of Health and Human Services (HHS) on Nov. 15, 2023. NYLAG supports many of the changes proposed in the above-referenced Notice of Proposed Rulemaking, and urges CMS to go farther in protecting dual eligibles. These comments specifically address elements of those proposals affecting individuals dually eligible for Medicare and Medicaid including older adults and persons with disabilities. NYLAG is particularly concerned about those dual eligibles who require Long Term Services and Supports [LTSS} to remain in their homes and communities, which they usually are required to receive from a Medicaid managed care MLTSS plan. Whether this Medicaid plan is aligned with a D-SNP ("Medicaid Advantage Plus" or PACE) or not aligned (called Managed Long Term Care plan (MLTC), access problems arise related to D-SNP marketing and enrollment.

ABOUT NYLAG & ITS WORK FOR AGING, LGBTQIA+ and DISABILITIES COMMUNITIES

Founded in 1990, New York Legal Assistance Group (NYLAG) is a leading civil legal services organization combatting economic, racial, and social injustice by advocating for people experiencing poverty or in crisis. Our services include comprehensive, free civil legal services, financial empowerment, impact litigation, policy advocacy, and community partnerships. NYLAG exists because wealth should not determine who has access to justice. We aim to disrupt systemic racism by serving individuals and families whose legal and financial crises are often rooted in racial inequality. NYLAG goes to where the need is, providing services in more than 150 community sites (e.g. courts, hospitals, libraries) and on our Mobile Legal Help Center. NYLAG's staff of 300 impacted the lives of nearly 90,000 people last year.

NYLAG has multiple units that work to enforce health care rights. Our Public Benefits Unit and Evelyn Frank Legal Resources Program advocate for low-income families, children, veterans, the elderly, Holocaust survivors, those living with disabilities, and other vulnerable populations to have access to the public benefits they are entitled to, including counseling on Medicare choices and resolving obstacles to obtaining Medicaid and Medicare eligibility and adequate services to enable them to remain in their homes and avoid institutionalization. LegalHealth partners with medical professionals to address the non-medical needs of low-income people with serious

health problems. NYLAG's LGBTQ Law Project provides low-income LGBTQIA+ communities with comprehensive civil legal services including access to care for transgender patients.

Our comments are keyed to the headings in the NPRM and are presented in the order discussed there.

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Program

A. Expanding Network Adequacy Requirements for Behavioral Health (§§ 422.116(b); 422.116(d)(2))

NYLAG supports proposals to expand network adequacy requirements for behavioral health. Just this month, the NYS Attorney General issued a report that, based on a survey of nearly 400 mental health providers listed on health plans' networks, found that the overwhelming majority, 86 percent, were "ghosts," meaning they were unreachable, not-in-network, or not accepting new patients.[1] "Inaccurate network directories are worsening the statewide mental health crisis and disproportionately impact marginalized communities, leading to adverse health outcomes, and increasing costs for patients," stated the press release announcing the report. Id. While the report and its survey focused on provider networks in Qualified Health Plans and Medicaid MCOs, many of the same providers no doubt are listed in networks for MA and D-SNP plans.

We endorse the comments submitted by the Legal Action Center and Justice in Aging's recommendation that CMS require network adequacy standards separately for Outpatient Mental Health and Outpatient Substance Use Disorder. We also recommend that CMS shorten the maximum time and distance standards to align with the standards for QHPs.

G. Parallel Marketing and Enrollment Sanctions Following a Contract Termination (§§ 422.510(e) and 423.509(f)) -- NPRM 78522

We support the change making marketing and enrollment sanctions take effect 15 days after contract termination notice is issued, rather than waiting until January 1st of the following year. Paragraph (e)(1) of 422.510 and paragraph (f)(1) of 423.509. As stated in the preamble, this timeframe is consistent with the number of days CMS often designates as the effective date for sanctions after CMS issues a sanction notice. Given the severity of plan violations required for imposition of such sanctions, these sanctions should be effective as soon as possible. Delaying them until the first of the following year makes consumers vulnerable to plan marketing for as much as a full year. For the same reason, we support the change that would no longer stay these sanctions pending the plan's appeal. The risk of harm to consumers is too great to suspend these sanctions pending the appeal.

We are particularly concerned about sanctioned D-SNP's being able to market to and enroll dual eligibles until the calendar year following the date the sanction is imposed. **In just one county –**

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[1] Office of the NYS Attorney General Letitia James, *Inaccurate and Inadequate: Health Plans' Mental Health Provider Network Directories,* Dec. 7, 2023, available at https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf, last accessed 12/30/23; press release posted at https://ag.ny.gov/press-release/2023/attorney-general-james-uncovers-major-problems-accessing-mental-health-care#:~:text=NEW%20YORK%20%E2%80%93%20New%20York%20Attorney,health%20crisis%20in%20New%20York.

Onondoga County -- the home of the consumer in case **Example 3** below (page 20, **4 out of 14 D-SNPs are sanctioned.**

Moreover, some HIDE and FIDE D-SNP's have been approved for "default enrollment" of NYS Medicaid recipients who have newly become enrolled in Medicare. Those who received Medicaid LTSS from their prior Medicaid managed care plan are now default enrolled into both the aligned FIDE D-SNP, which is part of the aligned integrated LTSS plan called Medicaid Advantage Plus or MAP. Similarly, those members of Medicaid managed care plans who are newly enrolled in Medicare and who do not need LTSS are default enrolled into the HIDE D-SNP aligned with their Medicaid managed care plan, and remain in that Medicaid plan, now recharacterized as an IB-DUAL Medicaid plan. If the aligned FIDE or HIDE D-SNP is under a sanction, default enrollment should be suspended immediately and not wait until the following calendar year. Consumers who are default enrolled have not chosen the plan – they are enrolled by default. Though they have the right to opt out, many do not understand this right or exercise it, and do not understand the pro's and con's of enrolling in D-SNP plans.

Examples of an HIDE D-SNP approved for Default Enrollment into an IB-Dual plan, but for which enrollment is suspended because the D-SNP is under sanction include Medicare Blue Dual (HMO D-SNP)(Excellus H7524-003) and Univera Medicare Dual (HMO D-SNP) (Excellus H7524-001)

H. Update to the Multi-Language Insert Regulation (§§ 422.2267 and 423.226)

NYLAG strongly supports the proposal to amend §§ 422.2267(e)(31) and 423.2267(e)(33) to require MA and Part D plans to provide a Notice of Availability in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency of the relevant State, rather than only in the 15 most common languages nationally. Additionally, we recommend amending the 5 percent threshold, which does not capture languages spoken by large segments of the population in more populated areas such as New York City.

According to the NYS Dept. of Financial Services, the US Census data reveals that the top 15 languages spoken in NY State includes at least **five languages** that are not on the list of the top 15 languages spoken nationally. These are **Bengali, Urdu, Yiddush, Greek and Hebrew**.[2] Our organization serves many LEP seniors and people with disabilities who speak these languages, many referred by partner organizations serving these communities. Indeed, while the Chinese population comprises nearly half of all Asians in New York City, the Bangladeshi population, for which **Bengali** is the primary language, "nearly tripled over the decade, to 102,000 in 2021. This increase vaulted Bangladeshis from sixth place among Asians in 2010 to third in 2021."[3]

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[2] Data from US Census website at https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html, https://www2.census.gov/library/data/tables/2008/demo/language-use/2009-2013-acs-lang-tables-state.xls. See also NYS website, listing top 12 languages spoken in New York State, three of which are not on the national top-15 list. See https://www.dfs.ny.gov/language_assistance, citing US Census data.

[3] NYC Dept. of City Planning, *Highlights from the 2021 American Community Survey*, available at https://s-media.nyc.gov/agencies/dcp/assets/files/pdf/data-tools/census/acs/dcp-nyc-highlights-from-the-2021-

A greater breadth of languages appears in New York City, which is well known as a haven for immigrants. According to the New York City website, "With more than 3 million foreign-born residents from more than 200 different countries, New York [City] is home to one of the most diverse populations in the world. New Yorkers come from every corner of the globe and speak **over 200 different languages**. Nearly one-half of all New Yorkers speak a language other than English at home, and almost 25%, or 1.8 million persons, are not English Proficient." https://www.nyc.gov/site/planning/about/language-access.page, accessed 12/22/23.

With such a wide variety of languages spoken in New York City, and with its large population, only two languages meet the 5% threshold in the NYC service area -- Spanish and Chinese languages -- which are on the top-15 national list. Requiring that the insert include the top 15 languages spoken in the state is critical to reach those speaking the 5 other languages listed above not on the national list.

Moreover, given the highly populated service areas in NYS – primarily New York City but also Long Island and other areas, we urge CMS to adopt a stronger standard than the 5% standard that would ensure these smaller language communities are getting notices in their language. For example, fewer than 5% of NYC residents speak either Albanian, Hindi, Punjabi, or Akan, which are not in the top 15 languages spoken in NYS or nationally. Still, for over 110,000 NYC residents these languages are their primary language.[4] Many plans cover a service area confined to New York City, or even to certain boroughs in New York City. These plans should be required to issue inserts in languages that are common in their service area, even if not meeting the 5% test. For example, the borough of Queens is well known to be a home to immigrants. **Punjabi** has been identified as one of the top 10 languages spoken in Queens, yet is not on the top 15 list in the state or nationally and does not meet the 5% test.[5]

NYLAG also strongly supports that the Notice of Availability must be provided in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.

NYLAG supports the other recommendations of Justice in Aging on language access.

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acs.pdf, posted on webpage https://www.nyc.gov/site/planning/planning-level/nyc-population/american-community-survey.page.page.

[4] See https://s-media.nyc.gov/agencies/dcp/assets/files/excel/data-tools/census/acs/dcp-lang-spk-at-home-nyc-boro_2021acs5yr-PUMS.xlsx (See *Detailed Language Spoken* tab) posted on https://www.nyc.gov/site/planning/planning-level/nyc-population/american-community-survey.page.page.

[5] See *Is Queens, New York, The Most Multilingual County In The World,* available at https://www.babbel.com/en/magazine/the-languages-of-queens-diversity-capital-of-the-world (2011-2015 survey) (Oct. 4, 2023), last accessed 12/22/23.

IV. Benefits for Medicare Advantage and Medicare Prescription Drug Benefit Programs

A. Evidence as to Whether a Special Supplemental Benefit for the Chronically Ill Has a Reasonable Expectation of Improving the Health or Overall Function of an Enrollee (§§ 422.102(f)(3)(iii) and (iv) and (f)(4))

NYLAG strongly supports the proposals to amend §422.102(f) to require that plans submit more documentation when they seek approval to offer or renew offers of SSBCI, to ensure that that an SSBCI "has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollees that the MA organization is targeting." FR 78538. Placing the burden of establishing evidence-based documentation on plans as enumerated in the proposed regulation will help ensure that SSBCI offerings are more than a marketing tool.

We particularly support the proposed requirement that plans document each determination that an enrollee is not eligible to receive an SSBCI." §422.102(f)(4)(iv). We further recommend that plans be required to submit this data to CMS as part of the annual review, rather than only make "this information available to CMS upon request." CMS could develop a template for reporting such data electronically. We further recommend that plans continue to document approvals of requests for SSBCI as well as denials, and calculate approval and denial rates, which would be included in the reports. The reports could include at least the following:

- The number of denials of SSBCI categorized by the most common reasons for denials.
- The data should be stratified by race, ethnicity, disability status, age, and LGBTQ status, in order to monitor that SSBCI are being implemented in an evidence-based, non-discriminatory, and fair manner. Without such stratification, it would be impossible to detect racial or other health disparities.
- Plans should report the data nationally but also separately for each state or smaller service area in which the plan operates. It is important to drill down to more local approval and denial rates, as national data may hide local disparities. Just as "[a]ggregate state-level rebalancing measures mask differences across populations and regions within states,"[6] so would aggregated national plan data mask local variations.
- If CMS requires a template for these reports to be filed electronically, the denial and approval rates could be tracked and compared between plans, between geographic areas by the same plan, between different D-SNPS operated by the same company, etc.

This would be a missed opportunity if CMS requires plans to keep this data but not report it to CMS for analysis.

Over the counter (OTC) cards and other cash benefits as an SSBCI: We urge CMS to strengthen requirements for plans to demonstrate the benefit of use of OTC cards with evidence-based documentation of impact of this SSBCI on health and outcomes. As shown by the examples in these comments, the OTC cards act as an inducement often at the risk of losing or experiencing

[6] Deborah J. Lipson, *Measures of State Long-Term Services and Supports System Rebalancing: HCBS Quality Measures issue Brief,* Mathematica, Nov. 2019, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf, p. 6.

disruptions in health care access – particularly access to long term care in NYS. CMS should scrutinize the use of cash benefits more and consider strategies to measure and ensure dual eligibles are not losing access to their health care. Given that anyone being offered an OTC card is by definition low-income, as they are either a full dual or a QMB beneficiary, these cards are clearly valuable and appealing to the consumers. However, if they are being enticed into these plans and then denied medical coverage with a value of thousands or even hundreds of thousands of dollars, then one cannot say the SSBCI has any benefit.

We join in related comments of Justice in Aging calling for clarification on how these cash benefits affect eligibility for Medicaid, SNAP, SSI, public housing, and other programs based on financial need. We support other comments by Justice in Aging as well.

B. Mid-year Enrollee Notification of Available Unused Supplemental Benefits (§§ 422.111(l), 422.2267(e)(42)

NYLAG supports the proposed regulation requiring plans to notify members during the month of June of any SSBCI and other supplemental benefits they have not used, and urges CMS to require plans to provide such notice with the EOC and also at key transition points, with additional info provided to Dual Eligibles. Proposed §§ 422.111(l) and 422.2267(e)(42).

Notice of SSB and SSBCI Accessed but Not Yet Exhausted - Respectfully, we disagree that the regulation would only require notice of benefits not accessed *at all* during the year. The notice should also include benefits partially accessed but that are not yet exhausted. For example, a member may have used a benefit earlier in the year that the plan approved in less than the amount requested at the time. The member may not realize that she may still quality to receive the benefit again later in the calendar year. These notices should state how much of the benefits remain available.

CMS requested comment on timing of this mid-year notice for members who did not enroll effective January 1st of the year. We recommend that the mid-year notice sent during July be sent to any enrollee who enrolled before June 1st of the current year. Anyone who enrolled between June 1st and August 1st should receive this individualized notice during September of that year, which would still give them a calendar quarter to use benefits they may not realize they have. The notice could be waived for anyone who enrolled after August 1st.

Additionally, we also recommend that CMS also require notice of unused SSB and SSBCI at different times during the year:

i. *Inform dually eligible members of Medicaid services that may be available* in a greater amount, duration and scope than those provided by the MA plan. This should be part of the mid-year notice of SSB not used.

ii. *The annual Evidence of Coverage (EOC) notice should be accompanied by an individualized letter stating which supplemental benefits the member did not access at all or did not exhaust during the previous CY* and describe the eligibility criteria, etc. Pointing out that the member did not access these benefits at all or fully would be more beneficial than solely listing the benefits in the EOC.

iii. *Expand care management responsibilities for all MA plans – especially D-SNP and other SNP's -- to inform members of supplemental benefits available, especially SSBCI, at the time of care transitions and coverage determination*s. This would include transition from hospital to rehabilitation facility and upon discharge from a rehabilitation facility. Notice should also be given when the plan denies or terminates Medicare home health services or skilled nursing facility services, since SSBCI and other supplemental benefits – as well as Medicaid benefits --could be beneficial at this juncture. Such notice would be required both on the initial notice of non-coverage and with any adverse appeal decision.

We support Justice in Aging's other comments on this proposal.

D. Annual Health Equity Analysis of Utilization Management Policies and Procedures (§§ 422.137(c)(5); 422.137(d)(6))

NYLAG supports CMS' continuation of the Biden Administration's deep commitment to promoting health equity, which CMS has worked hard to realize through past rulemaking, most recently the rule finalized in April 2023. We support the addition of health equity-related requirements to the Utilization Review procedure changes promulgated in April 2023.

We support is the amendment to § 422.137(d)(6) requiring that the UR committee newly required in the April 2023 rule must conduct an annual health equity analysis that would examine the impact of prior authorization at the plan level, on enrollees with one or more of the following social risk factors (SRF): (1) receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid (LIS/DE); or (2) having a disability. We appreciate that CMS is soliciting comments on whether the two above social risk factors should be expanded to include other populations in the health equity analysis, including those listed in the preamble to the regulations at page 78542. We strongly urge CMS to add the following risk factors, which may require improving data collection to track these demographics.

- **Members of racial and ethnic communities**

COVID-19 illuminated the racial inequities in access to primary, acute and long term care. In late 2020, 73% of New York nursing homes with a relatively high share of Black residents reported one or more COVID-19 deaths, compared with 54% of nursing homes with a lower share of Black residents, and with 59% of all NYS nursing homes.[7] A 10% gap was evident comparing New York nursing homes with a relatively high share of Hispanic residents with facilities with a low share. Id. Comprehensive and intersectional data collection and reporting is essential to identify racial and ethnic disparities in access to primary care, acute and long term services and develop strategies and policies to address those disparities.

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[7] Chidambaram, Neuman, et al., *Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes*, Kaiser Family Foundation, Oct. 27, 2020, available at https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes/, last accessed May 14, 2022; see also Rebecca J. Gorges, *Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US,* JAMA Network Open. 2021;4(2):e2037431. doi:10.1001/jamanetworkopen.2020.37431, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776102, last accessed May 14, 2022;

- **Members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community**.

As NYLAG stated in comments supporting Section 1557 regulations, discrimination against sexual- and gender-diverse persons in obtaining health insurance and coverage has long been a barrier to health care access, which has contributed to significant health inequalities.[8] LGBTQIA+ people report poorer health overall and are at increased risk of numerous health conditions such as sexually transmitted infections, HIV, obesity, substance abuse, and mental health conditions, including suicidality. They also are more likely than heterosexual individuals to acquire a disability at a young age.

Much of this can be attributed to well-documented discrimination. For instance, according to the 2015 U.S. Transgender Survey, 33% of all respondents reported discrimination in health care within the last year, including the refusal of necessary care because of their gender identity and verbal abuse by health care professionals.[9] The same report found that 23% of respondents had refrained from seeking health care within the last year due to fear of mistreatment, and 33% had not gone because they could not afford it.[10]

LGBTQ+ older adults experience pronounced health disparities and higher poverty rates compared to their heterosexual and cisgender peers due in large part to historical and ongoing discrimination. There is significant evidence that discrimination in health care contributes to these disparities: LGBTQ+ older adults may be denied care or provided inadequate care, or they may be afraid to seek necessary care for fear of mistreatment. For example, many LGBTQ+ elders and their loved ones experience discrimination in long-term care facilities ranging from verbal and physical harassment, to being denied basic care such as a shower, to visiting restrictions and isolation, to being improperly discharged or refused admission. Transgender older adults in particular experience discrimination in coverage of medically necessary care related to gender transition, as well as in coverage of lifesaving tests and treatments associated with one gender. Transgender people of color face significant barriers to health care access, from denials of gender affirming care to medical abuse.

While members of this community might not be readily identifiable by plans yet, CMS is taking steps to track this data. In November 2023, CMS issued guidance to state Medicaid agencies that addresses how states may add sexual orientation and gender identity questions to their Medicaid and CHIP applications.[11] CMS will not require states to report this data to CMS until about 2025, but CMS can separately require tracking of this data by plans or in the Medicare database so that

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[8] NAT'L ACADS. OF SCIS., ENG'G, & MED., UNDERSTANDING THE WELL-BEING OF LGBTQI+ POPULATIONS (Charlotte J. Patterson, Martín-José Sepúlveda, & Jordyn White eds., 2020), available at https://nap.nationalacademies.org/catalog/25877/understanding-the-well-being-of-lgbtqi-populations.

[9] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality HTTPS://TRANSEQUALITY.ORG/SITES/DEFAULT/FILES/DOCS/USTS/USTS-FULL-REPORT-DEC17.PDF

[10] Id.

[11] CMCS Informational Bulletin, *Guidance on Adding Sexual Orientation and Gender Identity Questions to State Medicaid and CHIP Applications for Health Coverage, Nov 9, 2023, available at https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf*.

it is available for all plans. This guidance also includes details on how this data must be kept confidential under federal law.

- **Individuals with limited English proficiency (LEP)**

It is well established that LEP individuals face barriers in accessing health care. Over 57 percent of older adults in NYC are foreign born.[12] In some boroughs like the Bronx, 35% of all older persons are LEP, the majority of whom speak only Spanish. Id. They are bombarded with notices about Medicare and Medicaid choices that are challenging even for those fluent in English and need access to language assistance. Older adults may be less inclined to ask for language assistance, out of a fear of inconveniencing others, even if the language assistance is necessary for them to truly understand their health care. LEP older adults may feel pressure to rely on family members as interpreters, even if those family members are not qualified to interpret health information, which can inhibit the older adult's understanding of their health status and instructions from their provider. Given the challenges of navigating a D-SNP or any health care plan for an LEP individual, it is imperative that LEP status be added to the list of social risk factors for tracking disparities in access to services.

- **Members of rural communities.**

NYLAG serves New York City so we have no direct experience with rural communities, but recommend that this be included as a risk factor based on reports from colleagues who work in rural areas in NYS.

The only population suggested in the preamble we would not include are "persons otherwise adversely affected by persistent poverty or inequality." This population is adequately captured by including dual eligibles and others receiving the low income subsidy, and would be difficult for a plan to identify otherwise.

We support the other recommendations of Justice in Aging that would strengthen the annual health equity analysis by establishing uniform definitions, a uniform format, and data underlying reported percentages, disenrollment data, disaggregated prior authorization data by type of item and service – such as home health and skilled nursing facility care.

V. Enrollment and Appeals

NYLAG broadly supports the changes in Section V of the proposed rule, addressing enrollment, appeals, and reporting. We appreciate the attention to detail around areas where enrollees may run into barriers accessing their Medicare benefits, and amending the rule to make the process smoother.

[12] See NYC Dept. For the Aging, *Profile of Older New Yorkers* (2022), p. 50, available at https://www1.nyc.gov/assets/dfta/downloads/pdf/reports/DFTA_Profile_of_Older_New_Yorkers_ACS_2019.pdf. ["DFTA Profile"].

A. Revise Initial Coverage Election Period Timeframe To Coordinate With A/B Enrollment (§ 422.62)

NYLAG supports the proposed extension of the ICEP timeframe for all of the reasons CMS states in the preamble.

C. Amendments to Part C and Part D Reporting Requirements (§§ 422.516 and 423.514)

NYLAG strongly supports the proposed clarifications of plan reporting requirements to improve transparency and accountability for pharmacy rejections, adverse initial determinations and appeal decisions, and decision rationales. We agree that the existing language requiring reporting of "patterns of usage" does not elicit the sufficient data needed for oversight of plan utilization decisions.

These amendments further the same goals as the proposed changes requiring plans to submit data elements as part of the annual health equity analysis of UM policies and procedures. 422.137(c)(5); 422.137(d)(6)(NPRM Sec. IV.D). We support and incorporate by reference the comments of Justice in Aging regarding the proposed requirements for data supporting the health equity analysis.

D. Amendments to Establish Consistency in Part C and Part D Timeframes for Filing an Appeal Based on Receipt of the Written Decision (§§ 422.582, 422.584, 422.633, 423.582, 423.584, and 423.600)

NYLAG supports the proposal to add five days to the 60-day appeal timeframe to Part C or D appeals in response to a written decision, and to add more days if there is evidence that the written determination was received later than five days. This proposal is consistent with appeals timeframes in Social Security, SSI and Medicare more generally and provides needed clarity for enrollees and their representatives.

The proposal also reflects the reality of slower post office delivery times in recent years,[13] as well as the frequent address changes requiring forwarding of mail that are common for low-income populations. With the end of the federal eviction moratorium that protected tenants during the COVID Public Health Emergency (PHE), housing instability has become more prevalent among lower-income individuals and families who may have moved one or more times during the course of the pandemic.[14] The Consolidated Appropriations Act, 2023 (CAA) and CMS in its implementing guidance, took into account the frequent changes of address for low-income people when it required States to take multiple steps to update addresses of Medicaid recipients before terminating their coverage due to non-receipt of the renewals sent in the "unwinding" of the PHE.[15] The proposed Medicare rule takes these same factors into account by allowing for

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[13] United States Postal Service. Revised Service Standards for Market-Dominant Mail Products, 86 Fed. Reg. 43,941 (Aug. 11, 2021) (final rule) (changing first class standards from 1-3 days to 1-5 days).

[14] AP News, Biden to Allow Eviction Moratorium to Expire Saturday, July 30, 2021.

[15] CMS State Health Official (SHO) letter, "Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions

time to appeal decisions, particularly for lower income individuals affected by delayed mail receipt.

E. Authorized Representatives for Parts C/D Elections (422.60 and 423.32)

We appreciate that CMS proposes to define the term "authorized representative" for purposes of eligibility, election and enrollment, as this term is ambiguous. The proposal would codify previous policy and define this term as defined under State law. We agree that this is a good baseline, but we often see problems for consumers who do not have a legally appointed guardian and who did not execute a durable power of attorney. States like New York do not have a surrogate consent law or substituted decision-making procedure that would enable a family member, for example, to stand in the shoes of a loved one who has dementia. This presents a problem not only in enrollment but also in making requests to MA, PDP and D-SNP plans for prior authorization, and in appealing denials of such requests.

We urge CMS to consider establishing a form or procedure by which a family member or other individual can attest to having a longtime trusted relationship with the consumer and act as their authorized representative for these purposes. It is simply a reality that many low income people have not done the planning for incapacity with an experienced attorney that most middle and high income people engage in. Wealthier people usually obtain a power of attorney or health care proxy in the course of doing estate planning or other financial planning. Given that they generally have no estates, low income people have not had the opportunity to prepare these advance directives. Plans routinely take advantage of this lack of a formal representative when they do not even permit a trusted family member to request a service or an appeal. CMS should recognize this reality and develop a policy and/or form to recognize trusted relations and caregivers and allow them to be designated as a representative for these purposes.

VI. Medicare Advantage/Part C and Part D Prescription Drug Plan Marketing and Communications

A. Marketing and Communications Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.2267)

Disclaimer language regarding the availability of SSBCI should be stronger regarding the consequences of enrolling in an MA D-SNP plan. We commend CMS for reviewing and strengthening the disclaimer requirements that were first implemented in 2022. § 422.2267(e)(34). The existing disclaimer has, as CMS points out in its preamble, led to confusion and misleads consumers into believing they will receive listed SSBCI benefits simply by enrolling in the plan or because they have one of the listed chronic conditions. However, we urge that the disclaimer be strengthened further by requiring D-SNP plans to clearly indicate which SSBCI and other supplemental services are available through Medicaid.

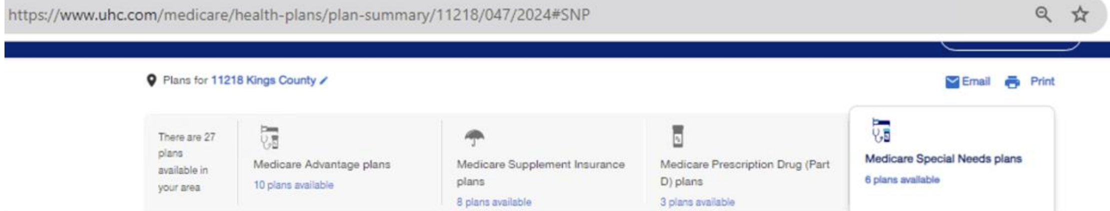
in the Consolidated Appropriations Act, 2023," Jan. 27, 2023, available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf.

We support these changes strengthening the disclaimer as to availability of SSBCI:

- requiring MA organizations offering SSBCI to list, in their SSBCI disclaimer, the top five (5) chronic conditions the enrollee must have to be eligible for the SSBCI offered by the MA organization. **We recommend that CMS specify the factors that plans must use in selecting which five chronic conditions to list, if there are more than 5 qualifying conditions.** Otherwise, plans could select conditions in a way that increases racial health disparities – such as by omitting sickle cell anemia from the list. Factors could include prevalence of the condition in the membership, and/or the top 5 chronic conditions of members approved for SSBCI in the past two years. Also, if a plan has more than 5 qualifying chronic conditions and opts to list only 5, the disclaimer must explain that there are other qualifying chronic conditions for the SSPBCI and hyperlink to them, if the disclaimer is online, or tell the member where they can find the complete list. Otherwise they will not know what other conditions may qualify.
- requiring the MA plan to specify that in addition to having one of the covered chronic conditions, that they must meet the eligibility criteria for the specific SSBCI. The actual coverage criteria must be available in the plan's Summary of Coverage, on the plan's website, and in the member manual. The disclaimer should tell the member how they can obtain these eligibility criteria, and hyperlink to them from any online reference.
- Requiring improved the formatting requirements in new § 422.2267(e)(34)(iv), and agree with CMS that the disclaimers have appeared in such small font that they are not visible.

We strongly urge CMS to adopt additional requirements requiring plans to specify what benefits offered by the D-SNP plan are already available to them under the Medicaid plan in their state. Just as we recommend for the Medicare PlanFinder, below, all D-SNP plan marketing materials should specify for each benefit – the SSP, SSBCI and basic benefits – what Medicaid covers. Plans may claim that they cannot provide state-specific information for 50 states. However, they purport to provide state-specific information, such as local provider directories. On the UnitedHealthCare website, if the consumer selects MEDICARE plans, the consumer is asked to enter their zip code, revealing local plans. The screenshot below appears if one enters a Kings County (Brooklyn) zip code (11218) and then clicks on *Medicare Special Needs plans*. This screenshot shows just the first of 6 SNP's that appear[16]:

[16] Available at https://www.uhc.com/medicare/health-plans/details.html/11218/047/H3387014002/2024?gclid=Cj0KCQiAhc-sBhCEARIsAOVwHuQK8_UNDJSL4wIpsiZl-9ywuvJ64lcHcez92sjFZepbNtL76GjM04UaApFyEALw_wcB&WT.mc_id=8030219&cid=ps%3Adsnp-ggl-uhc-bp-dual-complete-em-8030219%3A6531c1c6.



Medicare Special Needs Plans available for 2024

1 of 6 Plans

UHC Dual Complete NY-S002 (HMO-POS D-SNP)

Monthly premium $0 | Out-of-pocket maximum $0 | Estimated Annual Drug Cost: Add your drugs

Take advantage of many extra benefits that can help you live a healthier life. This plan is for people with Medicare and full Medicaid coverage.

Inpatient hospital	$0 per stay for unlimited days
Primary care provider (PCP)	$0 copay
Specialist	$0 copay
Annual medical deductible	$0
Prescription Drugs	$0 copay
Annual prescription deductible	$0

Additional Benefits

- $193 credit for food, OTC and utilities
- $1,000 for covered comprehensive dental
- 12 rides for doctor or pharmacy visits
- Eye exam and $350 eyewear allowance
- $2,000 allowance for hearing aids
- Get support from your Navigator

Add your doctors & dentists

Add your drugs

Show less

Enroll in plan | View plan details > | Save

If the consumer clicks to *View Plan Details*, the next screen reveals that this plan enrollment is limited: "Must be eligible for both Medicare and Medicaid and either be a Qualified Medicare Beneficiary or have Full Medicaid coverage in one of the following categories in NY: FBDE, QMB PLUS." This plan is a HIDE plan, approved for default enrollment in NYC for those enrolled in the aligned UHC Medicaid managed care plan, which, after enrollment into this D-SNP, is transformed into an aligned *Integrated Benefit – Dual* ("IB-Dual") Medicaid plan. Since a HIDE plan is required to provide extensive care coordination to dual eligibles, the lists of services should clearly identify which services may be obtained from Medicaid.

For those enrollees who solely have QMB and not QMB PLUS and who are not FBDE, the "extra" benefits offered by this and similar D-SNP's may be attractive, as these are not available through QMB. However, the plan marketing is also directed to those who have full Medicaid – FBDE and QMB plus – for whom the advertised "extra" benefits duplicate and are less expansive than what is offered by Medicaid. Marketing materials targeting FULL duals should make clear which benefits the individual can access through Medicaid.

- **Recommendation**: CMS should consider changing D-SNP eligibility so that certain D-SNP's are offered to full duals (FBDE and QMB PLUS), and others are offered only to those who only have QMB. Information about Medicaid services, which we maintain must be given to full duals, would be confusing for those who solely have QMB.

- **All plan marketing materials and EOC should specify which benefits are also available through Medicaid to reduce misleading marketing of SSBCI that duplicate Medicaid benefits.** This is not an unduly burdensome requirement, as the plans are already

tailoring each plan's information to a particular state. MA plans frequently advertise the availability of benefits to which individuals dually eligible are already entitled to receive more comprehensively in both duration and scope under Medicaid. The screenshot of a UnitedHealthCare HIDE Plan in NYS above illustrates this misleading marketing. It emphasizes as selling points no cost-sharing for doctors, hospitals and other basic services, and inclusion of limited dental, vision, and transportation benefits– all of which are benefits already covered comprehensively by Medicaid. Yet, the MA plan's marketing materials suggested that individuals who enroll would receive more than what they would receive in Original Medicare. In reality, there was only one benefit that was potentially "extra" – the $193 credit for healthy food, OTC products, and utility bills. Meanwhile, the disclaimer noted only that "limitations, exclusions, and/or network restrictions may apply" and that "Benefits, features, and/or devices vary by plan/area." Moreover, the online disclaimer appears at the very bottom of the plan webpage -- https://www.uhc.com/communityplan/new-york/plans/medicare/2024/dual-complete-plan-one-hmo-pos-snp/002 -- and most of it is only visible by scrolling down within a small field. This highlights the need for clearer and more robust disclaimer language than contemplated by this rule.

- **Networks: D-SNP vs. Medicaid -** Plan marketing materials and Evidence of Coverage (EOC) should make clear that not all providers in the D-SNP network also accept Medicaid, and tell the member how to tell which network providers accept Medicaid. In NYS in 2024, 80% of all in-network providers in HIDE and FIDE SNP's should also be Medicaid providers, an increase from the current 65%.[17] Given the overlap between D-SNP services and Medicaid services, especially D-SNP supplemental services, members must be clearly told the risk and consequence of using a provider who may be in the D-SNP network but who does not accept Medicaid. The webpage for the example UHC D-SNP above has nothing about this Medicaid provider issue at all, including under the large font heading "Important Provider Information." (Link in paragraph above)
    - **EXAMPLE 1 -Hardship to D-SNP Enrollee Who Did Not Realize In-Network Provider did not accept Medicaid** - A dually eligible consumer living in Oneida County in upstate NYS enrolled in one of the three UHC Dual Complete plans – UHC Dual Complete NY-S002 (HMO-POS D-SNP) (HMO-POS D-SNP)(H3387-014). This HIDE plan offers as a Supplemental Benefit limited dental coverage of up to $1000. The consumer has fee-for-service Medicaid. The consumer had oral surgery performed by an in-network dental provider, and the plan covered some of the cost. However, the provider billed the member for about $9,000 in "non-covered" charges. The consumer was surprised to learn that the dental surgeon does not accept Medicaid, even though she enrolled in a D-SNP plan which is specifically for dual eligibles. Since the service is not a Medicare service, QMB

[17] 2024 NYS State Medicaid Agency Contract between D-SNPs and NYS Dept. of Health, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2024/docs/cy2024_sma_contract.pdf, pp. 14 et seq.; 42 C.F.R. 422.66(c)(2).

protections and 42 CFR 422.504 (g)(1)(iii) do not prohibit balance-billing by the provider.

Agent Broker Compensation (NPRM at 78551)

NYLAG supports the comments of Justice in Aging requesting additional limits on broker activity. We commend CMS for recognizing that the lack of any commission when a broker enrolls an individual in Original Medicare rather than an MA plan creates an incentive to steer beneficiaries into MA plans. We agree that particular requirements should be imposed on brokers when communicating with dual eligibles to explain what services and costs are already covered by Medicaid for individuals dually eligible. Please see Justice in Aging comments for specific recommendations and concerns.

VIII. Improvements for Special Needs Plans

General Comment

NYLAG is very supportive of CMS's efforts to improve special needs plans and increase integration for individuals dually eligible for Medicare and Medicaid. We agree that the growing number of plan choices is overwhelming and confusing to consumers and reducing the number of health plan choices available to dually eligible individuals could be beneficial. However, CMS must adopt stronger requirements and exercise its enforcement powers to improve the integration and quality of care these plans are responsible for delivering. Limiting choice is broadly perceived as a negative outcome. If Medicare enrollees are to embrace less or different choice for better integrated and improved access to care, then the integrated MA plans actually have to deliver.

We join Justice in Aging in its general recommendations including:

- **Require all D-SNP providers to accept Medicaid** – particularly providers responsible for delivering supplemental benefits that overlap with Medicaid benefits. **Example 1** on page 14 above illustrates the misleading marketing of a HIDE-SNP in which a dually eligible individual enrolled, which failed to alert the consumer that she before receiving dental care as a supplemental service from an in-network dental provider, she should make sure the provider accepted Medicaid. She was billed for $9000 since the provider does not accept Medicaid. Since the service is not a Medicare service, QMB protections and 42 CFR 422.504 (g)(1)(iii) do not prohibit balance billing by the provider. It is hard to argue that the D-SNP's network meets the needs of the dually eligible population served as required by CMS.[18]
- **Ombuds Program -- T**his proposal does not include an ombuds program. The integrated care landscape is incredibly complex and builds on an already complex policy and health plan landscape for dually eligible individuals. One of the major successes of the Financial Alignment Initiative (FAI) was the use of an ombuds program to assist individuals in navigating Medicare-Medicaid Plans (MMPs). In NYS, the ICAN program launched when NY's FAI called "FIDA" existed, continues to advise and assist dual eligibles enrolled in

[18] CMS, Medicare Managed Care Manual Chapter 16-B: Special Needs Plans, Section 20.2.2, #5.

Medicaid MLTSS plans, including the integrated MAP plans. However, this program is not funded to assist consumers seeking to navigate the health care landscape for dual eligibles outside of LTSS. The local SHIP (HIICAP) program provides assistance on choosing, enrolling in, disenrolling from, and navigating D-SNP and other Medicare Advantage and Part D plans, but is not funded to provide full representation on all related issues. Expanding SHIP programs or Ombuds programs to service individuals enrolled in D-SNPS would fill a huge need for assistance with navigating these complex programs, along with identifying systemic issues.

C. Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization (§§ 422.503, 422.504, 422.514, 422.530, 423.38)

1. ***Changes to the Special Enrollment Periods (SEP) for Dually Eligible Individuals and Other LIS Eligible Individuals***

NYLAG strongly supports reinstating the continuous SEP that, prior to 2019, allowed dual eligibles and those receiving the *Low-Income Subsidy (LIS)* to switch Part D or Medicare Advantage plans monthly. The 2019 change allowing changes only once per quarter created a hardship for many of our clients, especially harmful during the last quarter of the year, when a change in plans is delayed as much as three months until the following January. Some were prescribed a new medication mid-year that was not on their plan's formulary, requiring them to change plans.

Nursing homes and rehabilitation facilities often change the consumer's Part D or Medicare Advantage plan during an admission for their own reasons. We have assisted consumers who cannot access prescriptions after they return home after a facility admission because the nursing home changed the Part D or MA-PD plan to one for which the consumer's preferred pharmacy is not in-network. Though there is a two-month SEP that allows changes for someone leaving a nursing facility, if the consumer misses that deadline, they need to use this SEP, and in some cases must wait until the next quarter.

We assisted a younger disabled consumer who needed to change plans after she was default-enrolled into a D-SNP after she became enrolled in Medicare. Her longtime behavioral health provider was not in the D-SNP network. She had to wait until the next quarter to change plans. Other consumers with Extra Help may have the bad luck of needing a new non-formulary prescription in one month, and another the next month because of a new diagnosis. They do not have the financial resources to pay out of pocket, unlike many other Medicare beneficiaries.

We have helped numerous beneficiaries obtain a deceptive marketing SEP to switch back to a previous MA or D-SNP plan. Since these SEP's require a high burden of proof and are difficult to obtain even with an experienced advocate, the continuous Dual SNP is much needed given aggressive marketing by D-SNP plans, as illustrated in the following **Example 2,** along with **Examples 3-5** below. Allowing the consumer to change plans monthly instead of quarterly would help mitigate the harm of these uninformed enrollments.

Example 2– Aggressive Marketing leads to Adverse Enrollment change, requiring SEP to reinstate *status quo*: Sonia, a 79-year-old naturalized citizen from Ecuador living in

Queens, NYC, was enrolled in the Healthfirst Life Improvement Medicare Advantage Plan, a HIDE D-SNP. A plan marketing rep convinced her son, who represents her as she has dementia, to switch her to a different Healthfirst D-SNP – a FIDE SNP called Healthfirst CompleteCare (HMO D-SNP) and at the same time into the aligned Medicaid managed MLTSS plan – Healthfirst CompleteCare *Medicaid Advantage Plus* (MAP). The marketer promised all of her doctors were in the new plan and all services would stay the same, and that the new plan offered a $250/month OTC card, better than the previous plan of $525/quarter. See https://healthfirst.org/over-the-counter-otc-benefits. By promising her services would stay the same, the rep implied that included her Medicaid home care services. But since these services were from her non-aligned Medicaid MLTSS plan ("MLTC") run by a different company, Centers Plan for Healthy Living, the enrollment change to the new D-SNP and its aligned MAP plan caused her to be disenrolled from the MLTC plan, *stopping her home care services entirely* on June 1st, 2023.

It took the NYLAG attorney three calls to the CMS SHIP Hotline before CMS approved use of a deceptive marketing SEP to cancel the D-SNP enrollment and reinstate enrollment in the original D-SNP. Since these SEPs are difficult to win, consumers in this situation may well need to use the Continuous Dual SEP. If she was limited to a quarterly change, she may have had to wait for months.

Complicating matters further, on June 1st --the very date of the D-SNP switch, a long-sought increase in her hours of Medicaid personal care was to take effect as the result of a pending Fair Hearing against the non-aligned MLTC plan. That fair hearing would be moot against the new MAP plan, depriving the consumer of that needed increase in home care hours. CMS could only reinstate the D-SNP enrollment, not re-enrollment in her Medicaid-only non-aligned MLTC plan. The NYLAG attorney had to advocate with the NYS Dept of Health and the plan to re-enroll her in the MLTC plan effective the following month, with rights as an existing member, rather than require her to go through a lengthy enrollment process as a new member. This aggressive advocacy successfully won reinstatement of the increased Medicaid personal care services won through the fair hearing. But the consumer suffered for a month with no Medicaid home care services.

Had CMS not granted the marketing SEP and if the consumer had to wait til the next quarter to disenroll from the FIDE D-SNP, this would have delayed reinstatement of her Medicaid personal care services, in part because NYS has exclusively aligned enrollment for FIDE D-SNPs and MAP plans. (NYLAG case ID 23-0549395).

We do not object that this continuous dual SEP could not be used to enroll in a different Medicare Advantage plan, except for integrated HIDE or FIDE D-SNPs. *(NPRM at 78568).* Limiting the SEP to enrollment in Part D plans or integrated D-SNPs should help reduce the constant marketing of Coordination Only D-SNPs that overwhelms dual eligibles year-round.

Finally, the continuous SEP will simplify client counseling. It is difficult to explain to consumers during the Annual Enrollment Period when they can change plans the following year if needed because of prescription changes or other reasons. We cannot tell them they can change plans once each quarter, since that is not true in the fourth quarter. Counseling on Part D and Extra Help coverage, often with related Medicaid and MSP eligibility counseling, is difficult enough – making this SEP consistent year-round will simplify that messaging.

NYLAG also supports the proposed integrated care SEP that would allow dually eligible individuals to enroll into or between integrated FIDE or HIDE D-SNPs on a monthly rather than a quarterly basis. *(NPRM at 78569).* We agree with CMS' proposal that this SEP would not be available to coordination only D-SNPs or other non-integrated Medicare Advantage plans, for which enrollment would be limited to the AEP, OEP or other SEPs. Case **Example 1** above as well as case **Examples 3 -5** below that illustrate this point.

4. Aligning enrollment effective dates – cut-off date of 18th of month (NPRM at 78570, 78577)

We appreciate that CMS is seeking comments on the alignment of enrollment effective dates where the consumer is enrolling in both a HIDE or FIDE D-SNP and an aligned Medicaid managed care plan, which in NYS is often an integrated MLTSS plan called *Medicaid Advantage Plus* or "MAP" or PACE. In NYS, in order for enrollment in a managed LTSS plan to take effect on the 1st of a month, the enrollment agreement must be signed by the consumer and submitted by the plan to the State's enrollment broker, Maximus d/b/a NY Medicaid Choice, before the 18th of the previous month. Otherwise enrollment in the MLTSS plan is delayed until the 1st of the following month. We presume the cut-off date of the 18th of the month is designed to allow enough time for the various electronic eligibility and payment systems to ensure that the plans receive their capitation payment and that the consumer appears on the plans' rosters for the following month.

From a consumer's point of view, this cut-off date causes delays in accessing LTSS services, for which enrollment in the MLTSS plan is crucial. These delays compound the delays built into NYS's LTSS system, which now requires the consumer to navigate two and sometimes three assessments by the NY Independent Assessor Program (NYIAP) before the consumer is approved to enroll in an MLTSS plan.[19] In case **Example 2** above at pp. 16-17, by the time CMS granted the deceptive marketing SEP, it was just a day before the cut-off date of the 18th of the month for the consumer to re-enroll in her former MLTC/MLTSS plan. This was not enough time to have a new enrollment agreement signed and submitted. The NYLAG attorney was able to secure re-enrollment in the MLTC plan through a complaint to the State health department, but if that had not worked, her re-enrollment in the MLTC plan would have been delayed an additional month beyond the one month of care she already lost because of the D-SNP marketing.

We are not proposing a particular solution for this problem. An obvious solution – to align the enrollment dates for the Medicaid plan with the D-SNP, is not feasible since consumers often are already enrolled in either the Medicaid plan or the D-SNP before enrolling in the aligned plan. Moreover, requiring aligned dates could backfire and harm consumers, such as by delaying receipt of services from the second plan. We agree with CMS that this is a challenging issue, and ask CMS to work with states, their enrollment brokers and with D-SNPs to clearly convey effective

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[19] See https://nyia.com/en and https://www.health.ny.gov/health_care/medicaid/redesign/nyiap/. See also critiques of this problem-ridden assessment system by NYLAG and other consumer advocates at https://medicaidmattersny.org/wp-content/uploads/2023/10/MMNY-ltr-delay-slow-NYIAP-expansion-10.20.23.pdf and https://medicaidmattersny.org/wp-content/uploads/2022/11/Joint-Consumer-Advocate-Plan-Association-Letter-on-NYIA-10.27.22-final.pdf.

enrollment dates, and urge states to make the cut-off date for enrollment in a Medicaid plan closer to the effective enrollment date.

NYLAG supports other comments made on this issue by Justice in Aging.

3. Enrollment Limitations for Non-Integrated MA Plans – Limit number of plan choices – FR 78570 --§§ 422.503(b)(8), 422.504(a)(20), and 422.514(h)(1) and (2)

NYLAG strongly supports the proposal that would limit, for D-SNPs that also operate a Medicaid managed care plan in the same service area, new enrollment into a D-SNP to those enrolled in or in the process of enrolling in the affiliated Medicaid managed care plan. **We urge that this rule take effect *before 2027* as proposed**. Additionally, we support the proposal that by 2030, would require the D-SNPs of companies that operate a Medicaid managed care plan in the area to disenroll members who are not in the affiliated Medicaid plan. Further, we support the proposal that by 2025, FIDE SNPs must have exclusively aligned enrollment. Sec. 422.2. We agree that these limits should apply when any part of the D–SNP service area(s) overlaps with any part of the Medicaid MCO service area, even if the two service areas do not perfectly align. This is especially important in NYS, where plan service areas may include numerous combinations of the state's 62 counties. Even NYC has five counties (boroughs), of which only some may be in a plan's service area.

During the Public Health Emergency, New York State relaxed the pre-PHE rules that formerly prohibited anyone with Medicare from remaining enrolled in a Medicaid managed care plan. Before the PHE, those who were newly enrolled in Medicare were involuntarily disenrolled from their Medicaid managed care plan; most had fee-for-service Medicaid. Some new duals enrolled in "Medicaid Advantage" plans, a fully integrated model has been replaced by enrollment in two aligned plans -- a HIDE D-SNP and an "IB-Dual plan," meaning *Integrated Benefit-Dual* plan. The IB-Dual plans are essentially the same as the former Medicaid managed care plan, for which the capitation rate has been adjusted for a modified service package including wrap-around Medicare coverage and Medicaid-only services.

During the PHE, NYS was approved to do "default enrollment" of some new dual eligibles into a HIDE D-SNP plan aligned with their Medicaid managed care plan.[20] The Medicaid managed care plans are recharacterized as an *Integrated Benefit-Dua*l ("IB-Dual") plan.[21] Some duals receiving LTSS are instead default enrolled in a FIDE D-SNP along with a "Medicaid Advantage Plus" ["MAP"] plan, which is a Medicaid managed LTSS plan aligned with the FIDE D-SNP.

However, default enrollment into this IB-Dual/HIDE D-SNP combo or the MAP/FIDE D-SNP combo has not yet been approved or rolled out statewide. As a result, many new dual eligibles are joining different D-SNPs or other MA plans that are not aligned with their Mainstream Medicaid

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[20] 2024 NYS SMAC, Supra, pp. 14 et seq.; 42 C.F.R. § 422.66(c)(2).

[21] NYS SMAC 2024 pp. 14 et seq. see also official NYS website about default enrollment and integrated plans is at https://www.health.ny.gov/health_care/medicaid/redesign/duals/index.htm. The list of HIDE D-SNPs approved for default enrollment and the counties approved can be viewed by clicking the dropdown labeled *IB-Dual - (Integrated Benefits for Dually Eligible Enrollees).*

managed care plan. This has caused great confusion and barriers to access that would be addressed at least in part by the proposed limitations on non-aligned D-SNP enrollment.

Case Example 3 below illustrates why NYLAG strongly supports the proposed rule that in 2027 would prohibit a D-SNP from enrolling a consumer who is a member of a non-aligned Medicaid plan, and in 2030 would require a D-SNP to disenroll a consumer who was not in the aligned Medicaid plan.   **We urge that these rules take effect earlier if possible.**

> **EXAMPLE 3**:   **Non-Aligned Enrollment Obstructs Access**. A consumer living in Syracuse (Onondoga County) was enrolled in the Fidelis (Wellcare) Medicaid Managed Care plan earlier during the PHE. Later, she first became enrolled in Medicare and, based on marketing, enrolled in one of three United HealthCare D-SNP plans offered in that county -- UHC Dual Complete NY-S002 (HMO-POS D-SNP)(H3387-014).   She remained enrolled in her Wellcare-Fidelis Medicaid managed care plan as permitted during the PHE, which is not aligned with the UHC D-SNP. She has been trying for months to get a particular back surgery authorized. Her UHC D-SNP plan approved the surgery, but the Wellcare-Fidelis Medicaid managed care plan denied prior authorization, even though it would only be paying as secondary coverage. She has been forced to delay the surgery because the providers will not agree to do the surgery without payment of the coinsurance.
>
> The UHC D-SNP she enrolled in is one of two HIDE D-SNP's in her county for which the State Medicaid program and CMS approved default enrollment into the aligned D-SNP and also into the "IB-DUAL" plan, meaning the aligned Medicaid managed care plan. The other D-SNP approved for default enrollment happens to be aligned with her Medicaid managed care plan -- Wellcare Fidelis Dual Access (HMO D-SNP H599-001). We do not know whether she received Default Enrollment notices to enroll in either D-SNP, but somehow, she ended up in non-aligned plans – creating a serious barrier to health care for her.   Given the complexity of this plan landscape, she did not understood the consequences of enrolling in a non-aligned plan; the enrollment in the UHC plan was the result of plan marketing of an OTC card, and she remained in her unaligned Fidelis Medicaid managed care plan by default. No unbiased counseling was provided or required before she made her plan choice.
>
> To troubleshoot this situation, we counseled her that as a dual, she has three options:
>
> 1. Disenroll from the Medicaid managed care plan and have Fee-for-Service Medicaid. At least then the provider can bill Medicaid – assuming they are a Medicaid provider and that the provider is due Medicaid reimbursement under New York's *lesser of* policy.
>
> 2. Switch her Medicaid coverage from a non-aligned Medicaid managed care plan to the aligned IB-Dual UnitedHealthCare Medicaid managed care plan – we presume that the IB-Dual plan would be required to cover the coinsurance for surgery approved by the aligned D-SNP – but if this is not the case, CMS should address this by regulation.
>
> 3. Switch from the UHC D-SNP to the Wellcare-Fidelis HIDE D-SNP aligned with her Medicaid managed care plan – though with this option she'd have to start the

prior approval process over for the needed surgery. For this option, the proposed integrated D-SNP SEP allowing changes on a monthly basis, rather than a quarterly basis, would be helpful.

Under the proposed rule, the UnitedHealthcare D-SNP would not be allowed to enroll this consumer, since she was a member of the non-aligned Wellcare-Fidelis Medicaid managed care plan. **We support this rule and urge that it take effect sooner than 2027 to protect consumers like the one in this example. Also, we urge that the "parent organization" be defined broadly for purposes of these contract limitations.** The CMS landscape file of plans lists the four Wellcare plans as sponsored by two different organizations – Wellcare and "Wellcare by Fidelis Care." (See chart below). These names result from a merger/acquisition. These four plans should be treated as offered by ONE parent organization.

NYLAG also supports the proposal that would allow CMS to contract with only one D-SNP with an affiliated Medicaid managed care plan that is operated by the same Medicare Advantage or parent organization offered in a service area. For the consumer in the example above, even if she chose to find a D-SNP aligned with her Wellcare-Fidelis Medicaid managed care plan, there are four such plans in her county, of which only the HIDE and FIDE plans are considered "aligned" and offer fully integrated care with an aligned Medicaid plan. Two others are Coordination only. These plans are listed in the chart below, excerpted from the 2024 CMS Landscape file.

TABLE 1: Wellcare D-SNPs – Onondoga County, NYS (2024)[22]

Organization Name	Plan Name	Type of Medicare Health Plan	Special Needs Plan Type	Integra-tion Status	AIP Status	Contract ID	Plan ID	Default Enrollment into Aligned IB-Dual or MAP plan
Wellcare	Wellcare Dual Access (HMO D-SNP)	Local HMO	Dual-Eligible	CO	No	H4868	004	
Wellcare	Wellcare Dual Access Open (PPO D-SNP)	Local PPO	Dual-Eligible	CO	No	H2775	112	
Wellcare by Fidelis Care	Wellcare Fidelis Dual Access (HMO D-SNP)	Local HMO	Dual-Eligible	HIDE	No	H5599	001	IB-Dual
Wellcare by Fidelis Care	Wellcare Fidelis Dual Plus (HMO D-SNP)	Local HMO	Dual-Eligible	FIDE	Yes	H5599	008	MAP

Similarly, UnitedHealthCare has three "Dual Complete" D-SNPs in her county – two CO plans and one HIDE plan. The consumer in the example above enrolled in the HIDE plan that is aligned with a Medicaid managed care plan for which NYS approved default enrollment into its IB-Dual product – but unfortunately not the IB-Dual plan aligned with her D-SNP. She ended up being enrolled in non-aligned D-SNP and Medicaid plans – a result that we support CMS in trying to prevent. To make matters even more confusing, UnitedHealth changed the plan names of its D-

[22] Source: CMS CY 2024 Landscape Files, available at https://www.cms.gov/medicare/coverage/prescription-drug-coverage, last accessed 10/5/2023.

SNP plans from 2023 to 2024, making it difficult for her advocate to pin down exactly which plan she is in. Certainly it is difficult to distinguish between these plans. See table below.

TABLE 2: UnitedHealthCare D-SNPs – Onondoga County, NYS (2023-2024)(CMS Landscape files)

Plan Name	Type of Medicare Health Plan	Special Needs Plan Type	Contract ID	Plan ID	Default Enrollment into Aligned IB-Dual or MAP plan
2023 UnitedHealthcare Dual Complete Choice 2024 UHC Dual Complete NY-S001	Local PPO	CO D-SNP	H0271	060	
2023 UnitedHealthcare Dual Complete Plan 1 2024 UHC Dual Complete NY-S002	Local HMO-POS	HIDE D-SNP	H3387	014	IB-Dual
2023 UnitedHealthcare Dual Complete Plan 2 2024 UHC Dual Complete NY-Q001	Local HMO-POS	CO D-SNP	H3387	015	

We strongly urge that the limitation on one D-SNP per insurance company also apply to Coordination-Only "CO" D-SNPs that do *not have an affiliated Medicaid managed care plan*. To limit this restriction to HIDE and FIDE SNP's creates an exception that swallows the rule. Clearly CO SNP's are proliferating and CMS should restrict this growth. We understand that the proposed limit of one D-SNP per company with an aligned Medicaid plan at least will prevent some non-aligned combinations as for the consumer above. But in the preamble to the proposed regulations CMS identifies other good reasons to restrict offerings to one D-SNP per insurance company, especially of CO plans, ie. to minimize consumer confusion by the overwhelming number of plans with very minimal differences. D-SNPs that are CO provide the lowest level of coordination and would likely continue to proliferate even if individuals dually eligible would only be allowed to enroll in these plans fewer times throughout the year. (NPRM at 78570).

We support the proposal that by 2025, FIDE SNPs must have exclusively aligned enrollment. Sec. 422.2. In NYS, for a dual eligible to enroll in a MAP (integrated LTSS plan), they must be enrolled in a specific aligned FIDE D-SNP. Just as the consumer is limited to enrolling in that particular FIDE D-SNP, the D-SNP's enrollment should be restricted to those duals who have been determined eligible for LTSS and are enrolling in the aligned MAP/LTSS plan. This restriction would help narrow the overwhelming number of choices for consumers and reduce duplication.

We support other recommendations of Justice in Aging.

4. *Request for comment on Enrollment in Integrated D-SNPs (FR 78576)*

We appreciate the invitation to comment on protections needed for enrollment in integrated D-SNPs. In NYS, over 51,000 dually eligible consumers are enrolled in fully integrated LTSS plans, which combine a FIDE D-SNP with an aligned Medicaid Managed LTSS plan. NYS has two types of fully integrated MLTSS plans -- PACE and *Medicaid Advantage Plus* (MAP). Most MAP plans have sister Medicaid-only non-integrated MLTSS (MLTC) plans, offered by the same insurance organization. These MLTSS plans are Medicaid-only, allowing the member to choose separate Medicare coverage, whether Original Medicare or an MA or D-SNP plan.[23] We have seen

[23] See website of the official NYS-contracted enrollment broker, NY Medicaid Choice (Maximus), for a list of all MLTSS plans, both integrated MAP and PACE and non-integrated MLTC (NYC: https://www.nymedicaidchoice.com/sites/default/files/content-docs/MLTC-PLANS-NYC-E-0923%209-25-

problems like the following cases where consumers fall victim to aggressive marketing and suffer adverse consequences regarding their LTSS benefits. The first example shows why additional protections are necessary before a consumer disenrolls from an aligned D-SNP and switches to a different D-SNP or MA plan. The second example illustrates protections needed before a consumer enrolls in an integrated D-SNP.

Example 4: Marketing Leads MAP/MLTSS member to disenroll from aligned D-SNP "A" and transfer to non-aligned D-SNP "B," causing disruption in LTSS services from integrated MLTSS *Medicaid Advantage Plus* plan aligned with D-SNP "A" – NYLAG client won an integrated administrative hearing that ordered her integrated MAP plan aligned with D-SNP "A" to increase her Medicaid personal care services from 6 hours/day to 24/7 care. Meanwhile, the member's son was marketed to by a different non-aligned D-SNP "B", which promised a monthly over-the-counter cash card. The son transferred the member to D-SNP B, not realizing that she would be disenrolled from the MAP plan because she was no longer enrolled in the aligned D-SNP "A." Upon that disenrollment – the first day of the next month, her personal care services *stopped altogether*. Though NYS has an enrollment broker, NY Medicaid Choice (operated by Maximus), D-SNP "B" was able to enroll the member without any intervention or counseling by the state's enrollment broker, since this entity plays no role in Medicare plan enrollments – only in enrollment in the aligned Medicaid plans.

NYS recently updated procedures that apply when a member of an integrated *Medicaid Advantage Plus* plan disenrolls from the aligned D-SNP. The guidance also lays out policy for other grounds of disenrollment from a MAP or MLTSS plans.[24] While this guidance is an improvement over previous policy, it does not do enough to *prevent* the above occurrence from happening. The MAP plan "…is required to make three reasonable attempts … over five business days to contact the Enrollee to inform them that the … Enrollee was no longer enrolled in the aligned … MA D-SNP." The guidance provides:

- If the Enrollee would like to remain enrolled in the MAP plan, the plan would assist the Enrollee in reinstating the enrollment in the aligned MA D-SNP, and enrollment in the MAP would continue.

- If the Enrollee acknowledges that the Medicare and Medicaid enrollment is not aligned and the Enrollee requests to voluntarily disenroll from the MAP plan, the plan is required to submit a completed *voluntary* disenrollment form to NYMC. We are especially concerned about the state's mischaracterization of such MLTSS disenrollment as "voluntary," without any confirmation from an unbiased source -- such as the State's enrollment broker or the Beneficiary Support System (BSS) -- that the consumer understands that changing the D-SNP will cause TERMINATION of the LTSS services and how to prevent this. In our experience, as shown by examples

23.pdf?language=en; Hudson Valley: https://www.nymedicaidchoice.com/sites/default/files/content-docs/MLTC-PLANS-Hudson%20Valley-E-0923%209-25-23.pdf?language=en; others at https://www.nymedicaidchoice.com/program-materials).

[24] NYS Dept. of Health, MLTC Policy 23.03, *Resumption of MLTC Involuntary Disenrollment Guidance*, Oct. 18, 2023, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/2023/2023-10-18_mltc_23-03.htm, also at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

above and below, MAP members have no idea that their home care and other LTSS services are linked to their Medicare plan. In such "voluntary" disenrollments, the State provides no procedures whatsoever to help the consumer transition to another MLTSS plan – allowing vital personal care or other LTSS services to simply stop cold.

- If the plan is unable to contact the Enrollee or if the Enrollee does not want to reinstate their enrollment in the aligned MA D-SNP plan, the plan is required to submit the *Involuntary Disenrollment Request Form* to the Maximus enrollment broker within five (5) business days. The enrollment broker would then notify mandatory enrollees (adult dual eligibles) that they may transfer to another non-integrated MLTC (MLTSS) plan, or they would be auto assigned to one.

The above state policy is an improvement over previous policy, which did not require the former aligned MAP/MLTSS plan to contact the consumer and give an opportunity to reinstate enrollment in the D-SNP, and did not assign them to another MLTSS plan, at least in those situations deemed to be "involuntary" disenrollments. We believe ALL such disenrollments should have the same protections as "involuntary" disenrollments.

CMS should strengthen protections to prevent loss of personal care and other LTSS received from aligned plans as a result of an unknowing change in D-SNP plans. This could be through marketing restrictions, and by requiring that the State enrollment broker review any disenrollment from an aligned D-SNP that results in disenrollment from an aligned Medicaid plan, especially one providing LTSS, and provide counseling to the consumer or their representative to ensure that they understand the consequences of switching Medicare plans on the consumer's Medicaid LTSS. If the new Medicare plan the consumer switched to was not a FIDE or HIDE plan aligned with a Medicaid MCO, the proposed enrollment restrictions would not prevent the problem that occurred here.

Moreover, the same drastic consequences to LTSS provided through an integrated MAP/MLTSS plan occurs if a consumer enrolls in a stand-alone Part D plan – a common occurrence during open enrollment with all of the marketing. The same avalanche of consequences occurs, including home care services stopping because the consumer is disenrolled from the integrated MAP MLTSS plan.

EXAMPLE 5 - Harmful Marketing to Enroll in a D-SNP and Aligned MLTSS Plan (MAP) – Jeopardizing Retiree Health Coverage and LTSS: A 90-year old Jamaican immigrant living in Brooklyn had appealed her non-integrated MLTSS plan's denial of an increase in home care from 12 hours/day to 24/7. Because of an injunction in a statewide class action, the plan was required to temporarily increase the home care to the requested 24/7 schedule, pending the outcome of the fair hearing. Her daughter had intentionally helped her keep Original Medicare in order to retain her retiree health insurance coverage, which would be jeopardized if she joined a Medicare Part D or MA-PD plan. The insurance organization that sponsors her MLTSS plan made a marketing call to her (as permitted by current rules since she was a member of one of its products) to urge her to enroll in their FIDE D-SNP and in the aligned Medicaid Advantage Plus (MAP) plan. The member and her daughter were promised that the D-SNP would cover all of her doctors, prescriptions, and preferred pharmacies, and would also provide generous over-the-counter cash benefits. The marketing rep did not ask whether she had retiree insurance coverage, and she and her daughter did not know to ask

whether this coverage would be affected. Further, the marketing rep misrepresented that her home care would remain the same. Yet on the first of the next month, when her enrollment in the aligned MAP plan took effect, her hours of home care were cut to 12 hours/day because the pending fair hearing against one plan was moot now that she changed plans. This was true even though both plans were offered by the same insurance company. NYLAG had to make multiple complaints to CMS, the NYS Dept. of Health and to Maximus, the NYS enrollment broker, which finally succeeded in reinstating her prior original Medicare coverage and enrollment in the non-integrated MLTSS plan and protecting her retiree insurance.[25] (NYLAG case no. 23-0541364).

This case illustrates the dire need for protections before enrollment in a FIDE D-SNP and its aligned MLTSS Medicaid MCO. Unbiased counseling must be provided before an enrollment. This counseling must advise the consumer about the impact of the change in Medicare coverage on receipt of Medicaid LTSS and other services, as well as about any retiree coverage. **Since states operating an MLTSS program must have a Beneficiary Support System, we recommend that this counseling function be provided by this BSS system rather than the Enrollment Broker**. 42 C.F.R. 438.71. In our experience, the enrollment broker does not have the depth of knowledge about LTSS services, procedural rights in fair hearings that may be impacted by a change from or to an aligned D-SNP plan, etc.

D. Comments Solicited on Medicare Plan Finder Improvements for Individuals Dually Eligible on D-SNPs – and related improvements for non-DUALS enrolled in SPAP's

NYLAG supports CMS' initiative to make improvements to Medicare Plan Finder (MPF) for dual eligibles so that Planfinder shows that services "not covered" by the D-SNP may be covered under Medicaid. We urge CMS to make similar improvements in Medicare Plan Finder for non-dual eligibles enrolled in their state's State Pharmaceutical Assistance Program (SPAP), showing potential cost savings using the SPAP.

The screenshot below is for a CO D-SNP in NYS for a dual eligible consumer logged into the website. The same plan benefit list and cost appears for the company's FIDE D-SNP - Hamaspik Medicare Choice (HMO D-SNP) H0034-002-0. The benefits listed under the "See more benefits" heading" highlighted with the blue arrow appear if one clicks on the link to "see more benefits."

[25] Both of these examples also supports the need for the Integrated SEP CMS proposes, discussed above in section III.4 of these comments. In these cases, NYLAG was able to secure retroactive disenrollment because of deceptive marketing. However, retroactive disenrollment is rarely approved because of the high burden required to prove deceptive marketing. Therefore, the proposed monthly SEP is crucial, allowing a quicker plan change than the quarterly SEP.

Hamaspik Medicare Select (HMO D-SNP)

Hamaspik, Inc. | Plan ID: H0034-001-0

Star rating: Not enough data available

MONTHLY PREMIUM

$0.00

Includes: Health & drug coverage

Doesn't include: $174.70 Standard Part B premium

This plan is designed for beneficiaries with Medicare and Medicaid.

SNP Type: Dual Eligible

TOTAL DRUG & PREMIUM COST (for 2024)

$135.00

Retail pharmacy: Estimated total drug + premium cost

Doesn't include: Health costs

PLAN BENEFITS

- ✔ Vision
- ✘ Dental
- ✘ Hearing
- ✘ Transportation
- ✔ Fitness benefits
- ✔ Worldwide emergency
- ✔ Telehealth

See more benefits

- ✔ Over-the-counter drugs
- ✘ In-home support
- ✘ Home safety devices & modifications
- ✘ Emergency response device

It seems feasible to adapt this list of benefits to include two columns of checkmarks rather than only one. The existing column of checkmarks would still indicate whether the benefit is covered by this plan. A second column would indicate whether the service could be accessed through Medicaid. We realize that detailed explanations of the scope of services covered by each state's Medicaid program may not be possible, but at least the fact that the service may be covered could be indicated by a clearly marked column as described above.

If CMS adopts the proposed regulation that would permit FIDE SNPS to enroll only individuals who are also enrolled in the aligned Medicaid plan, which we support, then it is all the more critical that Planfinder indicate what benefits are available through the aligned Medicaid plans, which in NYS are called *Medicaid Advantage Plus* plans. The supplemental service of "In-home support," "home safety devices & modifications" and "emergency response devices" are all core benefits of the integrated MLTSS product in NYS - *Medicaid Advantage Plus.* It would be very helpful for the availability of these services in the aligned Medicaid to be clearly indicated.

Moreover, the "X" mark showing that the above D-SNP plan does not cover dental, vision, and transportation services does suggest that the Medicare Advantage plans with a ✓ indicating that these services are included suggests that the non-D-SNP plans offer more generous benefits than D-SNPs. The reality, however, is that the benefit is available to dually enrolled individuals through Medicaid.

Some other suggestions for PlanFinder for dual plans:

- **Put D-SNPs at the top of the list when someone indicates they have Medicaid.**

- **Designate and clearly explain the level of integration: coordination-only, HIDE-SNP, FIDE-SNP, or AIP**. As said above, the FIDE-SNP designation would be especially important if these SNPs will only be able to enroll consumers who are eligible to enroll in and do enroll in the aligned Medicaid managed LTSS plan (Medicaid Advantage Plus). Similarly, HIDE SNPs in NYS align with "IB-DUAL Medicaid plans (Integrated Benefit – Dual) Medicaid plans, so that an explanation could be given that a consumer who wishes to have Medicare coverage aligned with their Medicaid coverage must be in a HIDE SNP plan offered by the same company as their Medicaid plan.

- **We disagree with the proposal that MPF would only list those Medicaid services offered through the AIP, and not Medicaid services carved out of the AIP.** (FR 78576). CMS is trying to address misleading listing of services offered by the D-SNPs that duplicate or supplement Medicaid services available to the consumer. That goal can only be accomplished by informing the consumer of all Medicaid services available, not only those available through the AIP. For example, NYS is planning to carve out NEMT from its managed LTSS benefit package, as it has carved this service out for other Medicaid MCO's. The carve-out for Managed LTSS has been postponed since 2021.[26] Description of NEMT transportation services on MPF is misleading for any dual eligible, whether or not they access that service fee-for-service through the carve-out, or through a Managed LTSS plan.

- **Identify the aligned Medicaid plan and give a link to that plan's website.** This should become feasible once CMS limits the number of D-SNPs that are aligned with Medicaid plans.

- **Indicate and explain clearly if a D-SNP and/or an aligned Medicaid plan are limited solely to people with LTSS needs, behavioral health needs**, or other needs.

We support other recommendations made by Justice in Aging.

State Pharmaceutical Assistance Programs (SPAP) Info in MPF --While not about dual eligibles, we urge CMS to consider including cost savings from enrollment in an SPAP. The NYS EPIC program is a state-funded SPAP for dual eligibles age 65+ who are not eligible for full Medicaid. See https://www.health.ny.gov/health_care/epic/. Since the billing system for EPIC is presumably linked to Medicare, perhaps there is a way for Planfinder to recognize that a consumer who has logged into the website has EPIC or another SPAP. Since there is a sliding scale of subsidies depending on the consumer's income, we realize it would be challenging to program Planfinder to take into account the EPIC subsidy. However, the search results could still indicate the SPAP's that exist in the consumer's state with basic eligibility requirements, and refer them to the SHIP program for counseling on how those costs are reduced by EPIC.

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[26] NEMT Carve-out info on State Dept. of Health webpage - https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/2020-12-14_draft_extension_app.htm#_bookmark9 (last accessed 12/30/23).

H. For D–SNP PPOs, Limit Out-of-Network Cost Sharing (NPRM at 78583) and Related Medicaid Cost-Sharing Concerns for D-SNPs (§422.100)

NYLAG strongly supports the proposal to limit cost-sharing for out of network providers for enrollees of the increasing popular D-SNP PPO's. **We ask CMS to implement this policy in plan year 2025 rather than 2026 considering the negative impact it has on dually eligible enrollees and state budgets.** We especially support limiting cost-sharing to the same amounts that would be charged in Original Medicare for chemotherapy, skilled nursing facility care, home health, supplies and other services, and that the cost-sharing would be less than Original Medicare in plans with a lower MOOP limit. CMS is rightly concerned that high cost sharing amounts could limit the number of Medicare providers who want to serve dually eligible individuals, who would be unable to pay these charges.

We remain concerned, however, about permitting D-SNPs to be PPO's or a limited type of PPO billed as an HMO-POS or Point of Service plan. Dual eligibles by definition have low incomes. It is deceptive to market a PPO model that appears to provide broader coverage – allowing out of network care – to consumers who cannot pay the cost of out of network providers – whether the plan charges a higher coinsurance or the plan does not cover the cost at all. For example, the United Health Dual Complete NY S-001 (HMO-POS) website explains "'Point-of-Service' means you can use providers outside the plan's network for an additional cost.'"[27] Yet the plan's webpage and Summary of Coverage do not clearly indicate what services may be obtained out of network, and at what cost. Only in the section titled, "Use Network Providers and Pharmacies" on page 14 of the SOB does it state that **only** for routine dental care you may use out of network care providers, but nothing else.[28] Yet the plan's webpage does not specify what the costs are for out of network dental services.

If PPO or HMO-POS plans are permitted, the costs for out of network care must be made clear in all advertising and plan documentation – which is not done now.

Related Issue – D-SNP Cost-Sharing Charges for Medicaid Services Received from In0-Network Providers that do not accept Medicaid

We urge CMS to address a related D-SNP billing issue where the plan approves "supplemental benefits" that are normally not covered by Medicare, but are covered by Medicaid. See **Example 1** above (p. 14) for an example of a HIDE D-SNP member being billed $9000 by an in-network dental surgeon who she did not realize did not accept Medicaid. She enrolled in the D-SNP plan which is specifically for dual eligibles and markets to Medicaid recipients. The D-SNP dental benefit was only $1000, and she should have been warned of liability for the balance due to a

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[27] See https://www.uhc.com/communityplan/new-york/plans?gclid=CjwKCAiAqNSsBhAvEiwAn_tmxSbIsN7ZMTdcnG-qGcJJqDKahXblJxjWzJrPbvb1R2vc52N5-JDbnhoC2xoQAvD_BwE&WT.mc_id=8030219&cid=ps%3Adsnp-ggl-uhc-bp-dual-complete-em-8030219%3A6531c1c6 (Scroll down to UHC Dual Complete NY-Q001 (HMO-POS D-SNP)).

[28] UHC Summary of Benefits 2024 https://www.uhc.com/communityplan/assets/plandocuments/2024/sob/en/2024-NY-SOB-H3387-015-001-EN.pdf?gclid=CjwKCAiAqNSsBhAvEiwAn_tmxSbIsN7ZMTdcnG-qGcJJqDKahXblJxjWzJrPbvb1R2vc52N5-JDbnhoC2xoQAvD_BwE&WT.mc_id=8030219&cid=ps%3Adsnp-ggl-uhc-bp-dual-complete-em-8030219%3A6531c1c6

provider who was in-network but did not accept Medicaid. The risk of such billing increases with SSBCI and other Supplemental services that are often covered by Medicaid but not by Medicare, so that QMB protections and 42 CFR 422.504 (g)(1)(iii) do not prohibit balance-billing.

The NYS D-SNP *State Medicaid Agency Contract* (SMAC), supra, specifically "does not require all providers to accept both Medicare and Medicaid," vaguely stating only that the D-SNP's network must meet the needs of the dually eligible population served." D-SNPs must simply "identify in their provider directory those participating providers that accept both Medicare and Medicaid." (SMAC page 8). See also CMS Medicare Managed Care Manual Sec. 20.2.2 #5. Since this is apparently a HIDE plan, the SMAC requires that in 2024 80% of the providers must accept both Medicare and Medicaid. SMAC Sec. G. This is up from 65% in 2023 – which is when the above consumer was treated. This network congruency requirement did not help this consumer, and would not help any consumers enrolled in CO plans – which have no such requirements.

We recommend that CMS strengthen the network alignment requirements to require all providers in a D-SNP network that markets to FBDE and QMB+ consumers must accept Medicaid. Even if the provider is designated in the D-SNP provider directory as one who does not accept Medicaid, which we do not know, it is misleading to market plans specifically for Dual Eligibles in which the providers do not accept Medicaid. Especially since many of the Supplemental benefits are ones that are covered by Medicaid, it is a bait-and-switch tactic to lure dual eligibles to a plan offering such benefits, and then subject them to balance billing if the provider does not accept Medicaid.

Another Marketing & Planfinder Concern about Medicare Advantage plans

While not part of this rulemaking, we urge CMS to review the need for marketing restrictions for Medicare Advantage plans, agents and brokers for MA plans that are not necessarily marketed to dual eligibles, and costs shown in planfinder for these plans and Medigap policies. Many of these plans highlight the fact that they have a ZERO or low premium, low copayments for primary care, and supplemental benefits such as gym, dental or vision coverage. However, they bury on their websites and do not mention in their advertising that enrollees are charged high coinsurance for high-cost services such as Skilled Nursing Facility, inpatient hospital deductible and daily coinsurance, and Part B coinsurance for expensive services like chemotherapy, infusions, DME, etc. The coinsurance for all of these services is usually about the same as it is in Original Medicare – if not more -- but an MA member by definition has no Medigap policy to pay these charges. If they are not eligible for QMB or Medicaid, they are liable for thousands of dollars for these charges until they reach the MOOP limit – which can be as high as $8,850 in 2024. That MOOP cap far exceeds the cost of a Plan G Medigap plan in NYC, of which the lowest cost is EmblemHealth at $302/month, or $3624/year.
https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates/Jan_2024_comparisons.

An example is AARP Medicare Advantage from UHC NY-0028 (HMO-POS)
https://www.uhc.com/medicare/health-plans/plan-summary/10002/061/2024#MA. The website does state the INPATIENT HOSPITAL coinsurance is $320 per day for days 1-5 and $0 copay per day after Day 5. But the main webpage makes no mention of Part B coinsurance other than primary care and specialists, nor of SNF coinsurance. Clicking on PLAN DETAILS shows a few of these charges including SNF: $0 copay for days 1-20 and $203 copay for days 21-100.

Only in the Summary of Benefits or Evidence of Coverage in the DOCUMENTS dropdown (https://www.uhc.com/medicare/alphadog/AANY24HP0123428_000 https://www.uhc.com/medicare/alphadog/AANY24HP0126056_000) would one find that Part B coinsurance for infusions, DME, etc. is 10% of the Part B approved amount. While this is half of the 20% coinsurance under Original Medicare, these Part B drugs can be $10,000 per dose, so 10% would be $1000. This would quickly meet the MOOP limit for this plan of $8300, alone or combined with 5 days in a hospital resulting in $1600 in coinsurance. A 5-day hospital stay alone cost almost half the cost of Medigap Plan G for an entire year in NYC.

Agents, brokers and MA plans should be required to advise potential enrollees of these potential costs, so they can make an informed decision between these plans and Original Medicare supplemented with a Medigap policy and stand-alone PDP. If an MA enrollee manages to avoid any of the services with high copays, then certainly the ZERO premium UHC plan described above would save money. But someone who is unlucky and needs costly services is liable for up to the $8300 MOOP limit -- more than *double* the cost of Medigap Plan G and a Part D plan. Too many consumers have no idea of these buried potential costs of an MA plan so are NOT making an informed decision.

In addition to burying these costs, plans bury the network limits and the rules requiring prior authorization for many more services than Original Medicare requires.

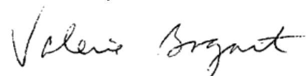
Moreover, Planfinder now offers to show Medigap options but does not offer a cost comparison based on use of different services like those above. Those who can afford a Medigap are certainly not being given the information they need to make an informed decision.

Conclusion

We have included numerous citations to supporting research, including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please feel free to contact us at rwallach@nylag.org.

Sincerely,



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