MEDICARE RIGHTS CENTER
Getting Medicare right

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January 27, 2025

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Attention: CMS–4208–P
P.O. Box 8010, Baltimore, MD 21244–8010

Re: RIN 0938-AV40—Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [CMS-4208-P]

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Contract Year 2026 Changes to Medicare Advantage and Part D** proposed rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

Our comments are informed by over thirty years of helping Medicare beneficiaries access the care they need. Medicare Advantage (MA) plans, while popular, are often a perilous choice for individuals with significant care needs, chronic conditions, or limited incomes. This is due to the administrative burden of accessing care within such plans, navigating narrow provider networks, and the artificial barriers the plans erect in the form of utilization management, including prior authorization and pre-and post-care coverage denials. Because of this, we applaud the proposals in this rule to clarify and strengthen consumer protections around internal coverage criteria and inpatient settings.

We also appreciate other changes included in the proposed rule that will improve coverage and affordability and those that will provide greater transparency and important safeguards for all beneficiaries.

II. Implementation of Inflation Reduction Act (IRA) Provisions for the Medicare Prescription Drug Benefit Program
C. Medicare Prescription Payment Plan
(c) Eligibility and Election

We approve of CMS's proposal to codify most of the guidance it created for the Medicare Prescription Payment Plan (MPPP). In particular, we approve of CMS's proposal for 2026 and subsequent years to require Part D sponsors to include information on the availability of the LIS program and other financial assistance programs in MPPP election-related materials with the goal of alerting Part D enrollees to the availability of these programs that can lower costs. These programs are underutilized and often incompletely understood, and they have a far greater impact on a beneficiary's ability to afford drug costs than the MPPP can. We urge even more consistent and consumer-tested outreach on these programs, including by standalone Part D plans as well as drug plans provided through MA enrollment (MA-PDs).

III. Strengthening Current Medicare Advantage, Medicare Prescription Drug Benefit, and Medicaid Program Policies

A. Part D Coverage of Anti-Obesity Medications (AOMs) and Application to the Medicaid Program

CMS proposes to cover AOMs to treat obesity. While we do not oppose this coverage, it must be coupled with steep reductions in the cost of these medications.

On January 17, HHS announced that Ozempic, Rybelsus, and Wegovy have been selected for price negotiation[1] and the accompanying fact sheet lists the Part D covered costs for these brands for a single 12-month period from November 2023-October 2024 as $14,426,566,000, covering 2,287,000 beneficiaries.[2] This astonishing number shows the need for negotiations to rein in the cost of these medications for the program, and for individuals, and to avoid runaway profiteering from pharmaceutical companies.

B. Network Transparency for Pharmacies

CMS proposes to require Part D sponsors to notify network pharmacies which plans the pharmacies will be in-network for in a given plan year by October 1 of the year prior to that plan year and upon request thereafter. We support these proposals. Beneficiaries who are considering MA with Part D or a standalone Part D plan must be able to determine which pharmacies will be in-network before selecting a plan.

C. Part D Medication Therapy Management (MTM) Program Eligibility Criteria

CMS proposes to modify the regulatory text identifying "Alzheimer's disease" as a core chronic disease to include "Alzheimer's disease and dementia" effective January 1, 2026. We support this proposal.

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[1] Department of Health & Human Services, "HHS Announces 15 Additional Drugs Selected for Medicare Drug Price Negotiations in Continued Effort to Lower Prescription Drug Costs for Seniors" (January 17, 2025), https://www.hhs.gov/about/news/2025/01/17/hhs-announces-15-additional-drugs-selected-medicare-drug-price-negotiations-continued-effort-lower-prescription-drug-costs-seniors.html.

[2] Centers for Medicare & Medicaid Services, "Medicare Drug Price Negotiation Program: Selected Drugs for Initial Price Applicability Year 2027" (January 17, 2025), https://www.cms.gov/files/document/factsheet-medicare-negotiation-selected-drug-list-ipay-2027.pdf.

D. Part D Sponsors Must Provide Network Pharmacies Reciprocal Rights to Terminate Contracts Without Cause and Request for Information on Access to Pharmacy Services and Prescription Drugs
1. Terminate Contracts Without Cause

CMS proposes to require Part D sponsors to allow pharmacies to terminate their network contracts without cause after the same notice period that the sponsor is allowed to terminate network pharmacy contracts without cause. We support this change to better balance the needs of the plans and the pharmacies.

E. Modifying the definition of "Service area"

CMS proposes to modify the definition of service area to include a definition of "county-equivalents" as recognized by the United States Census Bureau for economic census purposes. We support this definition.

F. Administration of Supplemental Benefits Coverage through Debit Cards
2. The Administration of Supplemental Benefits

CMS proposes to require MA organizations to have processes for delivering all MA organization covered supplemental benefits. We strongly support this proposal. For years, we have feared that MA organizations may not be delivering promised supplemental benefits. Given the role these benefits play in the selection process for many beneficiaries, more must be done to ensure that people are getting what they signed up for. MA is a tradeoff. Those leaving Original Medicare are losing that coverage pathway's superior provider access and streamlined access to care and may be sacrificing their future ability to sign up for Medigap. MA must be accountable for the benefits it promises in return.

3. New Guardrails for Plan Debit Cards

We have been concerned about the spreading use, and potential abuse, of MA debit cards. These cards are widely advertised and in our experience are enormously appealing to potential enrollees. Many MA enrollees have lower incomes and may struggle to make ends meet. But they may come at a cost if other public services like SNAP or housing benefits consider the flex cards to be income and adjust an enrollee's eligibility based on those purported assets.

For this reason, we applaud efforts to provide greater clarity and guardrails around these cards.

CMS proposes to require MA organizations to provide debit cards that are electronically linked to plan covered benefits through a real-time identification mechanism to verify eligibility of plan covered benefits at the point of sale. This means that a plan issued debit card must be electronically linked to the covered benefit through a real-time mechanism that ensures the enrollee is only able to receive covered items or services that they are eligible to receive at the point of sale. CMS also proposes to require MA organizations that use debit cards to provide instructions for debit card use, customer service support to answer questions or help with issues, and instructions to beneficiaries on the process to access benefits if not accessible by debit card. We support these proposals as a unit.

4. Access

CMS proposes that a plan must have an alternative process that allows for reimbursement of eligible expenses for plan covered benefits if enrollees are unable to use their plan debit cards, including situations in which a contracted vendor is not easily accessible due to an enrollee's transportation constraints. As above, we support this proposal. Debit cards rely on technology that may fail or may burden enrollees who cannot get to far-flung participating vendors.

CMS also notes that it expects MA organizations to "adequately disclose the process by which reimbursement may be made to enrollees and to ensure that the process is accessible to all enrollees"[3] and expects "MA PPOs to have processes to verify out of network reimbursement is only made for plan-covered services and to indicate to enrollees the process by which reimbursement can be made."[4] We urge CMS to codify these expectations to ensure plans thoroughly understand, and meet, their obligations.

5. Additional Disclosure Guardrails

CMS proposes to state that MA organizations must disclose any mandatory supplemental benefits (including reductions in cost sharing) or optional supplemental benefits, the premium for optional supplemental benefits, and any applicable conditions and limitations associated with receipt or use of supplemental benefits. This would include eligible OTC items and, where supplemental benefits are administered through a debit card, must specify which benefits may be accessed using the debit card. We support requiring these disclosures.

6. Marketing Supplemental Benefits

CMS proposes to prohibit MA organizations from marketing the dollar value of a supplemental benefit or the method by which a supplemental benefit is administered, such as use of a debit card by the enrollee to provide the plan's payment to the provider for the covered services. We strongly support this proposal regarding the method of administration. In our experience, many people are swayed by the inclusion of a flex or debit card.

But we are uneasy with a requirement that appears to limit the information potential enrollees can receive as to the actual value of supplemental benefits. Also in our experience, enrollees often believe supplemental benefits are more generous than they are.

CMS notes that, absent the dollar value or the method of administration, the ads provide the beneficiary with enough information to inquire further if the supplemental benefit would be helpful to their care, rather than an overly simplified advertisement that does not include the level of information required for an informed enrollment decision. While we agree that the ads do not include the level of information required, prospective enrollees already struggle to understand if a given supplemental benefit would be

[3] 89 Fed. Reg. 99340, 99388.
[4] 89 Fed. Reg. 99340, 99389.

helpful to their care and do not know where to turn. Reducing the amount of information available to potential enrollees may be counterproductive.

Because of this, we agree that the dollar value of the benefits should be removed in broadcast ads and billboards, but we urge additional safeguards. For example, all ads that advertise supplemental benefits could be required to identify that there are sharp limits on the coverage value, covered items and services, and individual eligibility. This should be in the same font and/or delivered at the same volume and tempo as the main body of the ad. These requirements would be akin to pharmaceutical product claim advertising that requires side effect disclosures.[5]

G. Non-allowable Supplemental Benefits for the Chronically Ill (SSBCI)

CMS proposes to codify a non-exhaustive list of examples of non-allowable SSBCI items or services. We support this clarifying proposal.

H. Eligibility for Supplemental Benefits for the Chronically Ill (SSBCI) and Technical Changes to the Definition of Chronically Ill Enrollee
1. Eligibility for Supplemental Benefits for the Chronically Ill (SSBCI)

CMS proposes that plans must publish on their public-facing website the objective criteria developed and used by the MA plan to determine whether an enrollee is eligible to receive the particular SSBCI benefits the plan offers, including how the plan evaluates each enrollee and determines whether the enrollee meets the three-pronged definition of a chronically ill enrollee as set forth in the statute. We support this proposal. Currently, there is too much ambiguity about who is eligible for these benefits and too much ability for plans to advertise their availability without expressly identifying the limits to access. Public transparency regarding these criteria is vital.

J. Ensuring Equitable Access to Medicare Advantage (MA) Services – Guardrails for Artificial Intelligence
2. Proposed Policy

CMS proposes to revise regulatory text to create a new paragraph to require MA organizations to ensure services are provided equitably irrespective of delivery method or origin, whether from human or automated systems. This is to specify that artificial intelligence or automated systems, if utilized, must be used in a manner that preserves equitable access to MA services. We support this proposal.

K. Promoting Community-Based Services and Enhancing Transparency of In-Home Service Contractors

CMS proposes to refine regulatory language to require plans to disclose: All direct furnishing entities from whom enrollees may reasonably be expected to obtain services; Each provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or

[5] Food & Drug Administration, "Basics of Drug Ads" (last accessed January 27, 2025), https://www.fda.gov/drugs/prescription-drug-advertising/basics-drug-ads#product_claim.

a skilled medical interpreter at the provider's office; Any out-of-network coverage; any point-of-service option, including the supplemental premium for that option; and how the MA organization meets the requirements for access to services offered under the plan. We support this proposal which will provide greater transparency about an MA plan's ties to the community and its capacity to deliver the benefits it offers.

In addition, CMS proposes to require plans to clearly identify all direct furnishing entities that provide in-home or at-home supplemental benefits or services, or a hybrid of these benefits or services, including easily identifiable notations, filters, or other distinguishing features to indicate in-home or at-home supplemental benefit providers. We support this proposal as one means to ensure that enrollees have a greater understanding of who will be entering their homes where they may be extremely vulnerable to bad actors.

CMS also proposes that plans would be required to create a subset of the provider directory through which plans identify in-home or at-home supplemental benefit service providers, including those that may provide a hybrid of services (both in-home or at-home, and in-office services). In the alternative, CMS proposes that plans could create a separate list. We have no preference between a subset or a separate list, so long as the enrollee or potential enrollee can find the information easily and the providers who may be entering their homes are not hard to identify.

L. Ensuring Equitable Access to Behavioral Health Benefits Through Section 1876 Cost Plan and MA Cost Sharing Limits

CMS proposes beginning in contract year 2026, to require that MA and Cost Plans (including EGWPs) set in-network cost sharing for behavioral health service categories to no greater than that of Traditional Medicare. We strongly support this proposal. In our experience, cost can severely limit access to behavioral health care and these barriers can put the well-being of individuals at grave risk.

M. Ensuring Equitable Access – Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures

CMS proposes to require plans to report the metrics by each covered item and service in the annual health equity analysis and an executive summary of the results. We support these changes. The greater granularity will help identify issues of concern and disparities, while the executive summary will help consumers and advocates better understand the reports.

Additionally, CMS is soliciting comments on adding "having a mental health or substance use disorder diagnosis" to the list of social risk factors that MA plans must use to conduct the annual health equity analysis. In our experience, denials are especially prevalent in the behavioral health space, and we strongly support this addition.

N. Medicare Advantage Network Adequacy
3. Plan Benefit Package Level Reviews

CMS is considering conducting network evaluations at the plan benefit package level to help ensure more consistent and thorough oversight of MA provider networks. We strongly support this change.

O. Promoting Informed Choice– Expand Agent and Broker Requirements regarding Medicare Savings Programs, Extra Help, and Medigap

CMS proposes to add three topics, LIS, MSP, and Medigap, to the specified list of questions and topics an agent or broker must discuss with a potential beneficiary prior to completing an enrollment. For LIS, this would include explaining the eligibility requirements, the effect on drug costs if eligible, and identifying resources where they can get more information on applying. For MSPs, CMS would expect agents and brokers to explain that state programs that can help with premiums and cost sharing costs exist, and additionally expect agents and brokers would be equipped to offer contact information for the state as a resource for a beneficiary to receive more information about their options and eligibility for those states where the agent is licensed and appointed to sell. For Medigap, agents and brokers would be required to discuss with beneficiaries the potential impact enrolling into a MA plan can have on Medigap Federal guaranteed issue rights, including that the beneficiary generally has a 12-month period under Federal law in which they can disenroll from the MA plan and switch back to Traditional Medicare and purchase a Medigap plan with Medigap Federal GI rights. In our experience, many people do not understand the interaction of Medigap and MA eligibility and too few eligible people enroll in LIS and MSPs or other state programs that can help them afford their care. This leads to people choosing MA in error or to choosing the wrong MA plan. We strongly support these proposals.

Building on these efforts further, CMS should consider whether to require agents and brokers to include information about how LIS or MSP enrollment intersects with plan selection—the implications of an enhanced Part D benefit, for example, or how breadth of formulary or network may be more important in light of enrollment in programs that reduce or eliminate cost sharing obligations. CMS should also require agents and brokers to discuss any state-specific Medigap rules and rights that supplement federal guaranteed issue rights.

CMS also proposes to require that agents and brokers pause to ask whether a beneficiary has any outstanding questions prior to an enrollment decision being made. We support this proposal.

P. Format Medicare Advantage (MA) Organizations' Provider Directories for Medicare Plan Finder

CMS proposes to require MA organizations to submit their plan provider directory data to CMS or HHS in a format, manner, and timeframe that CMS/HHS determines to allow for the MA organization's provider directory data to be integrated with Medicare Plan Finder (MPF). CMS also proposes to require MA organizations to update the provider directory data that is submitted or otherwise make available to CMS for this purpose within 30 days of receiving information from providers of a change. In addition, CMS proposes to require MA organizations to attest that the information being submitted to CMS/HHS under this new requirement is accurate and consistent with data submitted to comply with CMS's MA network adequacy requirements. We strongly support each of these proposals. In our experience, the most important criterion for most enrollees in choosing a plan is whether their preferred providers are

in network. Currently, there is no way to simply search MPF by provider(s). In addition, many provider directories are woefully inaccurate or out of date. Better integration of the directories and MPF would aid in consumer decision-making and increase transparency around, and scrutiny of, network adequacy.

Q. Promoting Informed Choice– Enhancing Review of Marketing & Communications

CMS proposes to eliminate the content standard of the marketing definition so that all communications materials and activities that meet the existing intent standard are considered marketing for purposes of CMS's MA and Part D marketing and communications regulations. We support this change. People with or soon to be enrolled in Medicare face an onslaught of ads and materials that are designed to confuse, mislead, or instill a fear of missing out. We encourage CMS to review as many of these materials as possible to weed out the egregious behaviors.

U. Enhancing Rules on Internal Coverage Criteria
1. Using Internal Coverage Criteria to Interpret or Supplement General Provisions

We applaud CMS's additional efforts to clarify the appropriate uses of internal coverage criteria. We especially appreciate the statement that "It is only in the rare instance when an NCD or LCD is lacking in specificity or clarity, that we would consider internal coverage criteria to be permissible to interpret or supplement general provisions." And that "internal coverage criteria cannot be used to add new, unrelated (that is, without supplementary or interpretive value) coverage criteria for an item or service that already has existing, but not fully established, coverage policies." These statements together should form a limiting principle around these criteria.

CMS proposes to add the term "plain language" in regulation text to make it explicitly evident that internal coverage criteria may only be used to supplement or interpret already existing content within these Medicare coverage and benefit rules, not to add new, unrelated coverage criteria for an item or service that already has existing, but not fully established, coverage policies. We support this addition. In the same vein, we also support CMS's proposal to make conforming edits to the "publicly accessible" requirements to replace the term "general provisions" with "the plain language of applicable Medicare coverage and benefit criteria."

CMS also proposes to remove the existing requirement that the MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services to be replaced by other guardrails. CMS cites the difficulty of demonstrating such clinical benefits. Rather than eliminating this requirement, we suggest that the clinical benefits cannot be proven because, in general, they do not exist. CMS even says that "Further, the qualitative explanations that the MA organizations have asserted as to why the benefits of the criteria used are highly likely to outweigh any harms are not often supported with reliable evidence." Rather than changing the standard, CMS should assess the plan policies based on the evidence the plans cite and reject policies that do not have reliable evidence. If plans cannot demonstrate that their utilization management policies provide clinical benefits that outweigh clinical harm, then plans must not be permitted to use such policies. We are also concerned that CMS appears to be starting with the presumption that there is evidence supporting MA policies. This should not be

the presumption. By CMS's own admission, MA enrollees are losing access to vital, medically necessary, and statutorily required care due to MA policies that the organizations cannot show have evidence to support them.

In general, we also note, plans should defer to actual medical expertise rather than accountancy or algorithms to support payment policies.

CMS requests comment on the option of a new requirement that the MA organization must demonstrate through evidence that the additional criteria explicitly support patient safety. While we have no explicit objection to a patient safety framing, we find "support patient safety" to be at least as ambiguous as the current standard.

2. Definition of Internal Coverage Criteria

CMS proposes to define internal coverage criteria as any policies, measures, tools, or guidelines, whether developed by an MA organization or a third party, that are not expressly stated in applicable statutes, regulations, NCDs, LCDs, or CMS manuals and are adopted or relied upon by an MA organization for purposes of making a medical necessity determination, including any coverage criteria that restrict access to, or payment for, medically necessary Part A or Part B items or services based on the duration or frequency, setting or level of care, or clinical effectiveness of the care. We support this definition.

CMS clarifies that information contained in Referenced Local Coverage Determination articles may not be used as internal coverage criteria when making coverage decisions on basic benefits. We commend this clarification.

CMS further clarifies that criteria developed by third parties may be considered internal coverage criteria when used by an MA organization in making medical necessity determinations. Further, that when multiple parts of an NCD or applicable LCD are being supplemented or interpreted with internal coverage criteria by an MA plan, every instance where the plain language of a Medicare coverage rule is interpreted or supplemented is considered internal coverage criteria, and each instance must be based on current evidence in widely used treatment guidelines or clinical literature and must be publicly accessible. Additionally, CMS reiterates that MA organizations are responsible to ensure that any algorithm or artificial intelligence they use complies with all applicable rules for how coverage determinations are made. We applaud each of these clarifications and restatements. MA organizations must not be permitted to hide behind ignorance or vendors' decision-making. The plans bear ultimate responsibility for ensuring fair and equitable treatment and access to guaranteed Medicare benefits for each enrollee.

3. Prohibitions

CMS proposes that a coverage criterion will be prohibited when it does not have any clinical benefit, and therefore, exists to reduce utilization of the item or service. We support this proposal as we feel that

coverage criteria that are solely aimed at delaying or denying access to care are extremely common. We also urge CMS to consider prohibiting the use of coverage criteria with minimal or weak clinical benefit. Overriding provider decisions should be the exception, not the rule.

CMS also proposes to prohibit an internal coverage criterion when it is used to automatically deny coverage of basic benefits without the MA organization making an individual medical necessity determination. We support this proposal as well. MA organizations must not be permitted to deny authorization in a blanket manner, mass denying hundreds of beneficiaries in a matter of seconds. We also urge CMS to prohibit near-blanket denials. Plans must not be permitted to avoid this rule by authorizing a handful of treatments and denying the vast majority.

4. Public Availability

CMS notes the current difficulty in accessing MA organizations' internal coverage criteria and proposes to require MA organizations to examine and identify each internal coverage criterion being used and mark or label it as such within their policy documents for readers to understand that the specific internal criterion noted is being applied and may be specific to the MA plan. In addition, CMS proposes to require that the evidence that supports each coverage criterion be connected to the criterion with a corresponding footnote.

We support these proposals. Currently, accessing the internal coverage criteria is difficult: The criteria pages are not prominent and may have ambiguous or non-intuitive titles like "Medicare Guidelines" and be filed under member forms or other resources[6]; while the protocols for gaining access—for example, supplying a name, agreeing to terms of service, receiving an emailed or texted code—are not arduous if the user wants to access a single plan's documents, they add up quickly; the documents in many cases cannot be printed, leaving readers unable to create a resource for themselves without either transcribing the text or using numerous screenshots; and the information is presented without clear guideposts to distinguish between internal and Medicare-originating criteria.

CMS also proposes that MA organizations must publicly display on the MA organization's website a list of all items and services for which there are benefits available under Part A or Part B where the MA organization uses internal coverage criteria when making medical necessity decisions, including the information as proposed earlier in this section via explicit text or a hyperlink, as well as any third-party vendor's name. In addition, CMS proposes to require the criteria webpage must be displayed in a prominent manner and clearly identified in the footer of the website, and must be easily available to the public, without barriers, including but not limited to ensuring the information is available free of charge, without having to establish a user account or password, without having to submit personal identifying information, in a machine-readable format with the data contained within that file being digitally searchable and downloadable, and include a txt file in the root directory of the website domain that

[6] *See, e.g.*, Alignment Health Plan, "Alignment Health Medicare Guidelines" (last accessed January 27, 2025), https://www.alignmenthealthplan.com/providers/alignment-health-medicare-guidelines.

includes a direct link to the machine-readable file to establish and maintain automated access. We strongly support these proposals.

CMS is considering requiring an annual report of this information. We support this proposal.

V. Clarifying MA Organization Determinations to Enhance Enrollee Protections in Inpatient Settings

1. Clarifying When a Determination Results in No Further Financial Liability for the Enrollee

CMS proposes to clarify when organization determinations may not be appealable due to the lack of enrollee financial liability by stating that it is only applicable to contracted provider payment disputes arising from a claim payment decision in which the enrollee's financial liability will not be affected by whether the payment determination is upheld or overturned. This means that the limitation is only applicable if there has been a claim payment determination, which necessarily requires a submission of a claim or other request for payment from a contracted provider or enrollee. We support this clarification.

2. Clarifying the Definition of an Organization Determination to Enhance Enrollee Protections in Inpatient Settings

CMS proposes to clarify that decisions made based on the review of an enrollee's need for continued care, commonly known as concurrent review, are organization determinations and that a decision by an MA organization made pre-service, post-service, or concurrent with the enrollee's receipt of services in an inpatient or outpatient setting is an organization determination requiring providing the enrollee (and the provider, as appropriate) with timely notice and applicable appeal rights. We support this proposal.

CMS also proposes to include concurrent reviews as a type of determination subject to the rules at § 422.138(c), which state that if the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause or if there is reliable evidence of fraud or similar fault. As CMS notes, patients and providers must be able to rely on an MA organization's approvals and an MA organization should not be able to later deny the services based on a lack of medical necessity if the continued treatment had already been approved. We support this proposal.

3. Strengthening Requirements Related to Notice to Providers

CMS proposes to strengthen requirements related to notice of a standard organization determination to require MA plans and applicable integrated plans to notify an enrollee's physician or provider—when the provider submitted an organization determination request or other circumstances where it would be in the enrollee's best interest for their provider or prescriber to receive notice of a decision related to an enrollee-submitted request—of an organization determination or integrated organization determination on a request for a non-drug item or service. This is in addition to the existing requirement related to notifying an enrollee. We support this proposal. Providers are often in the best position to

facilitate requests and appeals and to explain the options for changing the course of treatment and/or filing such appeals to their patients.

4. Modifying Reopening Rules Related to Decisions on an Approved Hospital Inpatient Admission

CMS proposes that if an MA organization approved an inpatient hospital admission, any additional clinical information obtained after the initial organization determination cannot be used as new and material evidence to establish good cause for reopening the determination. We support this proposal. Plans should not be able to second guess their own decisions and potentially change enrollee obligations based on information that was not available at the time of their initial decision.

W. Formulary Inclusion and Placement of Generics and Biosimilars

We welcome CMS's stated intention to more closely monitor Part D formularies to ensure the plans provide beneficiaries with broad access to generics, biosimilars, and other lower cost drugs.

V. Improving Experiences for Dually Eligible Enrollees
A. Member ID Cards, Health Risk Assessments, and Individualized Care Plans
a. Integrating Member ID Cards for Dually Eligible Enrollees in Certain Integrated D-SNPs

CMS proposes to require that applicable integrated plans (AIPs) provide enrollees with one integrated member ID card that serves as the ID card for both the Medicare and Medicaid plans in which they are enrolled. We support this requirement.

In our experience, it can be difficult to find some information about D-SNPs such as level of integration. Because of this, we urge CMS to consider encouraging or requiring plans to include plan types on the cards (e.g. "FIDE-SNP," etc.) to help enrollees, providers, and advocates understand the standards the plans must meet.

In addition, we join Justice in Aging in requesting that CMS monitor for any issues with an integrated card; consumer test to make sure the card design is understandable; seek feedback from enrollees and providers on how well the cards work; require a date issued for cards (to help with timeline issues as people churn on and off Medicaid or utilize Special Enrollment Periods to change coverage); and require that a person's Qualified Medicare Beneficiary (QMB) status be on the card to ensure against improper billing.

b. Integrating Health Risk Assessments for Dually Eligible Enrollees in Certain Integrated DSNPs

CMS proposes to require D-SNPs that are AIPs to conduct a comprehensive HRA that serves as a single integrated HRA for Medicare and Medicaid. We support this proposal.

We also join Justice in Aging in recommending that plans be held accountable for follow-up if HRA findings identify needs such as medical, dental or other oral health, behavioral health, or long-term services and supports.

d. Opportunities for Improvement

We appreciate and support the various proposals that would better center the enrollee in the development of Individual Care Plans.

However, we are concerned that AIPs, not to mention less integrated plans, may not truly be providing individualized planning and care delivery, in part due to a lack of effective oversight. Many MA organizations have moved into the D-SNP space seeking higher profits[7] and leveraging extensive Medicaid markets.[8]

These factors make it urgent to have strong oversight of these plans to ensure they are serving their target populations well.

We join Justice in Aging in urging random audits to verify if individualized care plans reflect the individual's care objectives as opposed to using standardized template language; analysis and action based on grievance data specific to the person-centered planning processes; structured opportunities for beneficiaries to provide feedback on person-centered care planning requirements, including their ability to actively lead the drafting process, make changes to their care plans, and have care plans reflect their needs and goals; quality measures, designed and selected with input from beneficiaries, that meaningfully measure the person-centered nature of care plans and overall care. Quality measures should prioritize the individual's satisfaction with their care needs, goals, community integration, and overall quality of life; publication of the outcomes of person-centered planning processes, including audits, recipient feedback, and quality measures; and rigorous corrective action plans for Medicare Advantage plans who do not meet requirements.

e. Assuring Enrollee Advisory Committee Input on MOC Updates

CMS proposes adding language to D-SNP enrollee advisory committee (EAC) requirements to include updates to models of care among the minimum required EAC discussion topics. We support this proposal.

f. Comment Solicitation – Making State Medicaid Agency Contracts Public

We strongly support CMS moving forward with making State Medicaid Agency Contracts (SMACs) public. These contracts, whether individual or model, contain vital information for dually eligible enrollees, advocates, researchers, policymakers, and the public, including state eligibility requirements, how plans

[7] Alison Poole & Mike Krentzman, "What, Why, and How Fundamentals for a D-SNP" (August 2023), https://www.wakely.com/wp-content/uploads/2024/04/d-snps-what-why-how.pdf.

[8] Rebecca Pifer, "Medicare Advantage unrest, Change Healthcare fallout and more big takeaways from insurers' Q1" (May 13, 2024), https://www.healthcaredive.com/news/insurer-takeaways-medicare-advantage-change-medicaid-q1-2024/715485/ ("We like the D-SNP business, not only because it can produce excellent profits, but monetizing our Medicaid footprint for dual-eligible share over time is going to be a significant growth catalyst for us…" Molina CEO Joe Zubretsky).

handle exclusively aligned enrollment, deemed coverage rules, care coordination and transition assistance, and cost-sharing assistance.

We also urge CMS to encourage states to allow for public feedback on SMACs by creating a feedback process to ensure that these important documents capture the lived experiences and knowledge of consumers, caregivers, and advocates to improve plan performance, as well as enrollee experiences and outcomes.

Conclusion

Thank you again for the opportunity to provide comments. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi
President
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