

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 23, 2017

OMB, Office of Information and Regulatory Affairs,

Attention: CMS Desk Officer

Sent electronically via email to: OIRA_submission@omb.eop.gov

Re: Medicare Advantage and Prescription Drug Program: ANOC and EOC: Form Number: CMS-10260 (OMB control number: 0938-1051)

Justice in Aging appreciates the opportunity to comment on the above-referenced documents. These comments primarily address the the draft D-SNP Annual Notice of Change (ANOC) and D-SNP Explanation of Coverage (EOC). We also include limited comments on the general MA-PD ANOC and EOC, looking only at how those general documents address the needs of dual eligible members..

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

Our comments focus primarily on parts of the ANOC and EOC where we believe CMS could provide better clarity to plan members who are dual eligible and/or Qualified Medicare Beneficiaries (QMBs).

1. D-SNP Documents

General Comment

Our general understanding is that the significant majority of D-SNPs only enroll full benefit dual eligible and, in some case, also accept QMB-onlys. Although we have not undertaken a review of enrollment restrictions of all D-SNPs, we believe that very few also enroll SLMB-onlys, and QI-onlys, and fewer still have any QDWI-onlys as members. We therefore urge that, when considering modifications to the ANOC and the EOC, CMS design the documents –and particularly the ANOC--around full benefit duals and QMBs, and then, as necessary, permit modification for any plans that, in fact, enroll other partial duals. Using that approach as a starting point could significantly simplify both documents.

Annual Notice of Change

- As in prior years, we continue to urge CMS to provide an ANOC that is specific to the individual. Thus, for example, on pp. 1 and 2, if the plan serves both individuals with cost-sharing responsibilities and others who have no cost sharing, the costs should be specific to the individual

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rather than using asterisks and requiring individuals to determine which category they belong to. Similarly, we urge personalization of Sec. 2.2 in plans that serve both individuals with and without cost sharing coverage. We also urge personalization of Sections 2.3 and 2.4 to highlight any changes in providers and prescription drugs used by the individual.

- In Sec. 2.1 We question the need for the three bullets. The LIS extends all year except for changes in marital status or death of a spouse and, even with death of a spouse, the survivor has a grace period. The bullets are confusing and not very helpful. They are not relevant to the purpose of the ANOC, which is highlighting changes in plan coverage.
- In Sec. 2.6, since every member of the D-SNP (except in the rare case where a plan has QDWI members) is either a full or partial dual eligible and thus qualifies for LIS, we urge changing all statements that talk about “if you get Extra Help” or say you “may” have different payments. The statements should be more direct: “Because you receive Extra Help” (the statement could be modified if the plan enrolls QDWIs.) Further, because all plan members receive the LIS, it also is confusing to include all the complexity of deductibles, coverage gap and the rest. While we recognize that there may be value in making all ANOCs similar across plan types, we believe that a more compelling consideration is clarity and brevity, particularly in the ANOC. If, however, CMS is committed to an apples-to-apples comparison of D-SNPs to other MA-PD plans, then we ask, at a minimum, that the agency limit that comparison to the EOC. The ANOC needs to be as simple as possible and only contain information that is directly relevant to members of the particular plan type.
- In Sec. 5.2, unless the D-SNP enrolls SLMB-only, QI-only or QDWI-only members, we urge dropping any reference in Step 1 to joining a Medicare supplement (Medigap) policy.
- In Sec. 6, change the heading to “No Deadline for Changing Plans.”
- In Sec. 8, the first bullet should be written to recognize that everyone receiving the ANOC already receives Extra Help (unless QDWIs are enrolled). We suggest the following rewrite: “‘Extra Help’ from Medicare. You are already enrolled in ‘Extra Help,’ also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty.” Also in Sec. 8, we question whether referring consumers to their state Medicaid Office for LIS applications is appropriate. Our expectation is that many state Medicaid Offices would simply refer individuals over to SSA.
- In Sec. 9.3, if the individual is enrolled in a Medicaid managed care plan, we recommend also including to plan name and contact information.

Explanation of Coverage

Ch. 1, Sec. 3.1. We suggest also recommending that the beneficiary also always show the provider the individual’s Medicaid card.

Ch. 1 Sec. 4.1. The sentence telling members that they must continue to pay Part B premiums unless it is paid by Medicaid should only be used if the plan enrolls QDWI members.

Ch. 1, Sec. 5.1. The last paragraph of this section states that CMS will send a letter annually listing other medical or drug insurance. It would be helpful to identify the month in which the beneficiary can expect the letter.

Ch. 2. We note throughout that, except for Medicare complaints, there is no place for email addresses and no reference to secure portals where information may be sent. Since email is becoming an increasingly important means of communication in health care, we ask that CMS consider incorporating email addresses into the template.

Ch. 2, Sec. 5. Add “lawful permanent residents” to the second sentence.

Ch. 3, Sec. 2.1. For plans that use sub-networks, we suggest requiring plans to add language explaining that changing PCP may mean that the member will also need to change other providers. We note that this is referenced in Sec. 2.3 but believe at least a cross-reference here would be helpful.

2. General MA-PD Documents

Annual Notice of Change

For all MA-PDs, we continue to urge CMS to provide an ANOC that is specific to the individual. This is particularly important for dual eligible and QMB members whose rights and payment responsibilities are significantly different from those of other plan members. Thus, for example,

- Sec. 1 should tell a member who is eligible for LIS that the individual can change plans at any time.
- Sec. 2.1 and 2.2 should tell Medicaid and QMB beneficiaries that they are not responsible for deductibles and co-payments.
- Sec. 2.6, instead of merely referring to the LIS Rider, should explain drug costs right in the ANOC and should indicate the actual premium that the LIS individual must pay.

Sec. 7. We question whether referring consumers to their state Medicaid Office for LIS applications is appropriate. Our expectation is that many state Medicaid Offices would simply refer individuals over to SSA.

Evidence of Coverage

Ch. 4, Sec. 1.1. We suggest revising the references to Medicaid and Medicare Savings Programs. First we think the emphasis should be reversed, focusing more forcefully on the billing protection. We suggest: “Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider. If you think that you are being asked to pay improperly, contact Member Services at XXX).” References to SLMB, QI and QDWI should be dropped since these programs only cover Medicare premiums, not out-of-pocket costs.

Ch. 4, Sec. 1.6. This section discusses protections from billing above plan-approved amounts but does not address improper billing of QMBs and dual eligible. We urge CMS to add a reference here to additional billing protections for individuals who receive cost-sharing from Medicaid. We think it is particularly important to add the reference here since many dual eligible are accustomed to using the term “balance billing” to describe their protection against co-insurance charges.

Thank you again for the opportunity to comment. If you need additional information, please do not hesitate to contact me at JGoldberg@justiceinaging.org.

Sincerely,

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

Jennifer Goldberg
Directing Attorney
Justice in Aging