PAN Foundation

805 15th Street NW, Suite 500, Washington, DC 20005 T 202-347-9272

February 10, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; CMS-4201-P

Dear Administrator Brooks-LaSure:

On behalf of The Patient Access Network (PAN) Foundation, one of the nation's largest charities, I write to provide comment on the Centers for Medicare & Medicaid Services' (CMS) 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs proposed rule. We laud the Biden administration for making progress to increase access to health care and coverage.

PAN is an independent, national 501(c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic, and rare diseases with the out-of-pocket costs for their prescribed medications. PAN provides patients with direct assistance through nearly 70 disease-specific programs and collaborates with national patient advocacy organizations to provide patients with education and additional support. Since 2004, we have helped more than 1 million underinsured patients.

PAN provides the following comments on the proposed rule:

1. Expand eligibility for the LIS benefit under Part D

PAN has long been a supporter of expanding the Low-Income Subsidy (LIS) to increase the number of enrollees that receive assistance and thereby increasing the affordability of medications. The proposed rule proposes to implement Section 11404 of the Inflation Reduction Act (IRA) to expand eligibility for the full LIS benefit to individuals with incomes between 135% and 150% of the FPL beginning on January 1, 2024. In addition, PAN supports CMS' implementation of the IRA provision allowing for individuals to qualify for the full subsidy based on the higher resource requirements currently applicable to the partial LIS group. This is critically important for those who historically have been eligible for the full-benefit LIS, as it minimizes the potential resource burden on them.

While we greatly support this effort, we are concerned that those beneficiaries between 135% and 150% of the FPL are not auto-enrolled into a LIS-eligible plan, and therefore, may not know they may be eligible for the full benefit. To that end, PAN recommends that CMS explore opportunities to educate the newly eligible beneficiaries as well as those currently eligible but not enrolled. PAN recommends that any information that discusses the Medicare program also describe how the Part D LIS helps

qualifying individuals cover their out-of-pocket drug costs. PAN also recommends that CMS consider increasing and making permanent Medicare funding for low-income outreach and enrollment efforts, which have been extended 11 times since 2008 under the Medicare Improvements for Patients and Providers Act (MIPPA).

Further, PAN encourages CMS to include LIS information within communications to Medicare Savings Program (MSP) enrollees. Quite often, low-income beneficiaries identified as potentially eligible for MSPs have incomes and/or assets just above the eligibility thresholds but are within the higher thresholds for LIS eligibility. In these instances, information and assistance with LIS enrollment can be critical. It is imperative that outreach and enrollment efforts are comprehensive and recognize that there may be a range of other important, untapped benefits for these eligible individuals.

2. Extend the LI NET demonstration to a permanent program

PAN thanks CMS for, per the 2020 Consolidated Appropriations Act, proposing to codify in rulemaking making the Limited Income Newly Eligible Transition (LI NET) Program a permanent part of Medicare Part D beginning in 2024. PAN fully supports this program and values its contributions to the lives of low-income, Part-D-eligible individuals. LI NET provides temporary Part D prescription drug coverage for low-income Medicare beneficiaries not yet entitled to Part D. Yet not all stakeholders are aware of this program and the essential assistance it provides.

PAN appreciates CMS' proposal to maintain core components of the LI NET demonstration. The LI NET demonstration ensures that beneficiaries transitioning from Medicaid to Medicare do not experience a gap in coverage for prescription medication, and it enrolls eligible individuals automatically. CMS proposes to codify the eligibility for LI NET to include full-benefit dual-eligible individuals and LIS-eligible individuals who have not yet enrolled in a prescription drug plan or a Medicare Advantage (MA) prescription drug plan or who have enrolled but coverage has not taken effect. PAN appreciates that the permanent LI NET program will continue to provide retroactive drug coverage to ensure that beneficiaries have access to their prescription drugs.

Because enrollment in LI NET is temporary, PAN encourages CMS to consider additional outreach to LI NET enrollees to ensure that beneficiaries have time to choose the appropriate Medicare Part D prescription drug plan. Currently, if a beneficiary does not select a plan during LI NET, Medicare will enroll them into a benchmark plan automatically. By conducting additional outreach, CMS can support beneficiary access to the appropriate Part D plan.

3. Ensuring Timely Access to Care: Utilization Management Requirements

PAN supports the prior authorization provisions in the proposed rule and urges further reforms in future rulemaking. While prior authorization is intended to ensure that health care services are medically necessary by requiring providers to obtain approval before said service will be covered by insurance and contain health care costs, current prior authorization requirements may create barriers and delays to receiving necessary care, create confusion, and ultimately harm patients.[1] Furthermore, a recent survey

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[1]Jeannie Fuglesten Biniek and Nolan Sroczynski, Over 35 Million Prior Authorization Requests Were submitted to Medicare Advantage Plans in 2021, Kaiser Family Foundation, February 2, 2023, *available at* https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-

of over 1,000 physicians conducted by the American Medical Association revealed that prior authorization can lead to absenteeism and a less productive health care workforce.[2] PAN shares in CMS' goal of patient-centered care and applauds the proposed changes made to prior authorization requirements.

- Prior authorization policies for coordinated care plans may only be used to confirm the presence of a diagnosis, which will reduce the number of denials.
- An approval granted through prior authorization must be valid for the duration of the approved course of treatment and that plans must provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new plan, ensuring patients do not have interruptions in coverage when they need it the most.
- MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in statute and regulation, which will help standardize processes.
- MA plans cannot deny coverage of a Medicare covered item or services based on internal, proprietary, or external clinical criteria not found in traditional Medicare policies, which will also standardize processes.
- If there are no coverage criteria in the previously mentioned sources, the MA organizations may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, which minimize plans claiming that their decision making is proprietary.
- MA plans must establish a Utilization Management Committee to review all utilization management, including prior authorization policies annually, which help ensure compliance.

In future rulemaking, we request CMS consider policy changes to reflect clinical validity, transparency, and fairness related to prior authorization.

4. Advancing Health Equity

PAN lauds CMS' commitment to the advancement of health equity through the CMS Framework for Health Equity and supports CMS requirements that promote culturally competent care for MA plans, including the proposal that MA organizations include providers' cultural and linguistic capabilities in provider directories. If finalized, this change would improve the quality and usability of provider directories, particularly for non-English speakers, limited English proficient individuals, and enrollees who use American Sign Language. PAN also supports CMS' proposal that MA organizations must address health disparities as part of existing requirements to develop and maintain quality improvement programs.

5. Update Medicare Advantage (MA) and Part D marketing and communication

PAN commends CMS for proposing changes to marketing and communication materials that will protect Medicare beneficiaries by ensuring they receive accurate and accessible information about Medicare

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2021/#:~:text=Prior%20authorization%20is%20intended%20to,covered%20by%20a%20patient's%20insurance. Last visited February 3, 2023.

[2] Andis Robeznieks, Why prior authorization is bad for patients and bad for business, AMA, February 18, 2022, available at https://www.ama-assn.org/practice-management/prior-authorization/why-prior-authorization-bad-patients-and-bad-business. Last visited February 3, 2023.

Advantage and Part D coverage. This includes taking steps to help ensure any marketing of MA plans is not confusing, inaccurate, or misleading. This is especially important in light of MA and Part D marketing being the subject of a Congressional investigation,[3] CMS rulemaking,[4] and CMS subregulatory guidance in 2022.[4]

PAN is supportive of CMS' efforts that encourage accurate communication to plan enrollees, including prohibiting the marketing of benefits in a service area where those benefits are not available and requiring agents to explain the effect of an enrollee's choice on their current coverage. PAN encourages CMS to provide explicit guidance for insurance agents that details appropriate communication between agents and enrollees. Specifically, guidance should ensure that agents properly and clearly explain the following: the effect of an enrollment choice on an enrollee's out-of-pocket costs, premiums, drug coverage, and in-network vs out of network coverage for healthcare providers.

While we appreciate CMS' commitment to ensuring transparent and fair marketing, we also believe updates and improvements to Medicare.gov's Plan Finder tool would align with this proposed rule. The current Plan Finder tool does not have an integrated provider directory that allows enrollees to search for plans based on their chosen provider's in-network or out-of-network status. Updating the Plan Finder tool with an integrated provider directory would enable enrollees to better understand the impact of their enrollment choice on their current coverage. Additional updates to the Plan Finder tool will allow enrollees to easily find and compare benefits.

Currently, the Plan Finder tool does not prominently display utilization management requirements and drug restrictions, nor has it been updated to reflect the $35 insulin copay cap or the $0 cost-sharing on vaccines covered by Part D. Finally, the Plan Finder tool should allow enrollees to easily compare additional benefits, like dental coverage, for MA plans. Updating the Plan Finder tool would further support enrollees and protect Medicare beneficiaries.

6. Failure to collect and incorrect collections of Part D premiums and cost-sharing amounts

PAN appreciates CMS' efforts to align Part D requirements with existing MA requirements for incorrect collections. PAN is also supportive of CMS' new proposed Part D requirements, including the proposal that would require a Part D sponsor to make a reasonable effort to collect monthly beneficiary premiums and ensure collection of cost-sharing at the time a drug is dispensed. PAN supports updating the coordination of benefits requirements and the establishment of a 3-year lookback period for premium adjustments and claims adjustments unrelated to coordination of benefits. PAN appreciates CMS' work to streamline requirements for incorrect collections and supports CMS' proposal to have Part D plan sponsors refund identified enrollees for overpayment.

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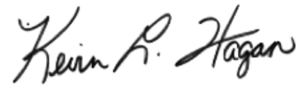
[3] Wyden reports deceptive marketing practices in Medicare Advantage that harm seniors. US Senate Committee on Finance. November 3, 2022. Accessed January 17, 2023. https://www.finance.senate.gov/chairmans-news/wyden-reports-deceptive-marketing-practices-in-medicare-advantage-that-harm-seniors

[4] Centers for Medicare & Medicaid Services. Medicare Program; Contract Year 2023 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit programs; policy and regulatory revisions in response to the COVID–19 public health emergency; additional policy and regulatory revisions in response to the COVID–19 public health emergency. Final rule. May 9, 2022. Accessed January 17, 2023. https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf

The PAN Foundation appreciates your leadership in seeking solutions to increase equitable access to and affordability of health care for more Americans. Thank you for your consideration of our comments. If you would like further information or have questions, please contact Amy Niles, Chief Advocacy and Engagement Officer at aniles@panfoundation.org.

Sincerely,



Kevin L. Hagan
President and Chief Executive Officer