July 25, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

The undersigned organizations write to request that the Centers for Medicare & Medicaid Services (CMS) strengthen Program of All-inclusive Care for the Elderly (PACE) participant protections against Medicare Advantage (MA) fraudulent and misleading marketing practices. This issue is especially acute in the PACE space due to the proliferation of MA marketing of over-the-counter (OTC) benefit or cash cards, though the issue is not limited to this type of supplemental benefit. Our members report consistent disenrollments of PACE participants enticed to enroll in non-integrated MA plans offering lucrative cash cards.

The financial and health implications of uninformed enrollment, or altogether false inducement, in MA plans are especially acute for PACE participants, nearly half of whom (46%) live with dementia. Further, the vast majority of PACE participants have multiple, complex medical conditions and/or functional impairments, and significant health and long-term care needs not comprehensively addressed by MA plans. These situations suggest that MA plans are not currently complying with the new marketing requirements established in the Contract Year (CY) 2024 MA, PACE, and Part D final rule (CY 2024 final rule)[1], which requires brokers to conduct a pre-enrollment checklist (PECL) informing beneficiaries of the effect on their current coverage (42 CFR § 422.2267(e)(4)(viii)).[2] Minimally, it appears that further CMS guidance is necessary to clarify the breadth of what information CMS intended MA plans convey to beneficiaries.

We appreciate the efforts CMS has taken over the years to curb MA predatory marketing and inappropriate plan steering, including in the most recent CY 2025 MA, PACE, and Part D final rule (CY 2025 final rule).[3] These practices not only distort healthy competition among plans but, more importantly, pose significant and potentially dire health risks for affected enrollees when considering access, cost, and coverage differences between and among plans. Further, PACE enrollees, in particular, are being encouraged to move to non-integrated options that are not in their best interests. This practice hinders CMS' goals to move more individuals dually eligible for Medicare and Medicaid into integrated models and also demonstrates brokers are not acting in beneficiaries' best interests, which was a fundamental goal of the PECL. Therefore,

[1] https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf
[2] https://www.ecfr.gov/current/title-42/part-422/section-422.2267#p-422.2267(e)(4)(viii)
[3] https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

further clarification of this requirement is necessary to ensure that brokers note, when applicable, that the plan being considered will not cover the beneficiary's long-term services and support (LTSS) needs or other Medicaid benefits and eligibility, such as accessible transportation to their doctor's appointments.

In the CY 2025 final rule, CMS codified provisions aimed at curtailing pervasive and aggressive marketing practices conducted by Third Party Marketing Organizations (TPMOs). CMS acknowledged that "the overwhelming number of marketing calls beneficiaries receive from TPMOs are *unwanted, confusing, and inhibit the beneficiary's ability to make an informed choice*" [emphasis added]. We could not agree more. Importantly, in the CY 2025 final rule, CMS also updated special supplemental benefits for the chronically ill (SSBCI) marketing and communications requirements to prevent misleading marketing of these benefits that make it appear that these benefits are available to everyone when, in fact, they may not be. Collectively, our members report that this MA marketing practice has led to PACE participants disenrolling from PACE to enroll in MA, only to re-enroll in PACE, typically within the month, upon determining that the MA benefits and cost-sharing were not what they expected. In particular, we are hearing about the use of cash cards as an inducement to leave PACE and enroll in MA plans.

One such example, conveyed by a PACE organization, follows.

> *Multiple participants disenrolled from PACE to enroll in a MA plan that enticed participants to enroll by offering lucrative cash cards. The MA plan coordinated transportation for the former PACE participants to their upcoming doctor visits via non-medical, public rideshare services, such as Lyft or* Uber. *However, unlike in PACE, where the transportation driver is part of the 11-member interdisciplinary team (IDT) and specially equipped transportation is provided to participants, the beneficiaries were unable to use the rideshare serves because they ambulate using wheelchairs. This caused the beneficiaries to miss critical medical appointments. Eventually, the former PACE participants returned to the PACE organization to reenroll in PACE. At that point, though, the participants' health had declined because of missed medical appointments. This led to significant health, administrative and financial (including out-of-pocket costs typically covered by PACE but not covered by MA) to the participant.*

In addition to the troubling and extensive loss of benefits and supportive services that occur in a switch from PACE to a general MA plan, we are also concerned about the impact on other benefit qualifications for these low-income, vulnerable populations. For example, if a PACE participant switches plans for the purpose of accessing a cash card, this action may impact their eligibility or financial obligations in federally subsidized housing, Medicaid, or Supplemental Security Income (SSI).

While CMS' efforts to address deceptive MA marketing practices are commendable, they are not enough. Stronger enrollee protections are needed to ensure that beneficiaries have accurate and appropriate information to make a fully informed decision *prior* to enrolling in a MA plan. This is especially critical for PACE participants for whom disenrollment from their PACE plan to enroll in a MA plan would likely result in increased out-of-pocket costs and far less comprehensive coverage.

Recommendations of CMS

Ahead of the forthcoming CY2026 MA, PACE and Part D proposed rule (CY 2026 proposed rule), we respectfully request that CMS include additional protections to promote beneficiary choice and ensure informed decision-making. Specifically, we call on CMS to:

- Require MA plans to explain all out-of-pocket costs and network/coverage limitations clearly and fully, based on standardized language, to prospective enrollees *prior* to their enrollment in a MA plan.

- Stipulate additional measures during the PACE participant voluntary disenrollment process (42 CFR § 460.162[4]) – e.g., requiring written revocation of PACE coverage analogous to the Medicare hospice benefit – to ensure the authenticity and intentionality of the participant's voluntary disenrollment. One aspect of the revocation process should include why the disenrollment occurred that would allow tracking of the number of revocations occurring for this reason.

- Permit mid-month enrollment in PACE for former PACE participants to re-enroll in PACE if beneficiary wants to return to PACE following their disenrollment from a MA plan. Although beneficiaries can disenroll from a MA plan or Part D plan to enroll in PACE at any time, pursuant to current requirements, the beneficiary may face a significant coverage gap given that a participant's enrollment in PACE is not effective until the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement (42 CFR § 460.158[5]). Participants who elect to re-enroll in PACE within two months of disenrollment should be allowed to enroll mid-month. The PACE organization should receive a prorated reimbursement for that month to help support a smooth transition of care.

- Clarify that when MA brokers inform beneficiaries of the comparative benefits of their current coverage (e.g., PACE) to an alternate MA plan that the broker inform them, in plain language, if they would be enrolling in a plan that does not cover or coordinate their Medicaid benefits; and any benefits the individual would "lose" under the new plan (e.g., transportation to groceries).

These measures, along with potentially other mitigation efforts, are vital to prevent PACE participants from experiencing a detrimental break in their PACE or Medicaid coverage including potential disruptions in the receipt of care and, for PACE organizations, from foregoing typically a month or more in lost Medicare or Medicaid revenue (i.e., the time until PACE coverage is reinstated).

In closing, we respectfully request a meeting with you and your staff to discuss this issue in further detail, along with potential policy solutions to safeguard PACE participants and other beneficiaries. Please contact Katie Pahner, vice president, Regulatory Affairs, at NPA at

[4] https://www.ecfr.gov/current/title-42/section-460.162
[5] https://www.ecfr.gov/current/title-42/section-460.158

KatieP@npaonline.org; or Georgia Goodman, Director, Medicaid Policy, at LeadingAge at ggoodman@leadingage.org. Thank you in advance for your consideration of this request.

Sincerely,

Shawn Bloom
President and CEO
National PACE Association

Katie Smith-Sloan
President and CEO
LeadingAge

CC:
Jonathan Blum, MPP, Principal Deputy Administrator and Chief Operating Officer
Kathryn Coleman, Director, Medicare Drug and Health Plan Contract Administration Group, Center for Medicare
Tim Engelhardt, MHS, Director, Medicare-Medicaid Coordination Office
Cheri Rice, MPP, Deputy Director, Center for Medicare
John Scott, JD, Director, Medicare Parts C and D Oversight and Enforcement Group, Center for Medicare
Meena Seshamani, MD, PhD, Deputy Administrator and Director, Center for Medicare