AltaMed

January 12, 2018

Seema Verma, Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted via www.regulations.gov

Subject: Medicare Program: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare fee-for-service, the Medicare Prescription Drug Benefit Programs, and the PACE Program [CMS-4182-P]

Dear Acting Administrator Verma:

AltaMed Health Services is one of the nation's largest Federally Qualified Health Centers in the nation. We have been providing quality health and human services to individuals and families in Southern California for 48 years. Each year we serve more than 5,500 Medicare Advantage (MA) beneficiaries across Los Angeles and Orange Counties as a contracted physician organization. We also serve over 2,400 PACE participants as an independent PACE Organization in Los Angeles County. We write today as a key stakeholder to provide feedback regarding the proposed policy changes and updates for the Medicare Advantage, the Prescription Drug Benefit Program and the PACE Program.

Medicare Advantage outperforms traditional Medicare in quality and cost. It is a model of care that strengthens our health care delivery system and assists us in providing care for some of our most vulnerable patients. We applaud CMS' commitment to supporting flexibility and efficiency throughout this model of care. Below we offer specific comments on these proposals which we have prepared in collaboration with our trade associations America's Physician Groups (APG) and the National PACE Association (NPA).

Ensure Additional Transparency for Star Ratings

In the proposed rule, CMS makes a number of proposed changes to the Medicare Advantage Star Ratings system. AltaMed supports America's Physician Groups' (APG) comments which are summarized below:

a. APG supports the agency's proposal to codify changes to the Star Rating system beginning in the CY 2019 measurement year (2021 Ratings; 2022 payment year).

CMS proposes to codify the Part C and Part D star Ratings system beginning with the CY 2019 measurement year. APG has consistently advocated for the use of the formal federal register notice and comment rulemaking to make changes to the Stars system and other aspects of MA payment. We believe that this is a critical step forward in improving program transparency and allowing stakeholders an opportunity to fully understand the proposals and provide better feedback to the agency as a result. We appreciate the agency's responsiveness to these requests.

b. APG agrees with the guiding principles for quality measurement as set out in the proposed rule.

CMS details a set of principles for changes to the MA and Part D Star ratings system. APG supports the agency's guiding principles. We emphasize the importance of aligning clinical quality measurement across different programs. Today, APG members participate in a wide variety of risk contracts with different payers, MA plans, traditional Medicare, Medicaid managed care plans, and commercial plans. Each of these payers have different measure sets that they are using to grade our members' quality performance. As physician organizations pursue higher levels of risk with multiple contracting partners, alignment across programs would go a long way to reduce burden and improve the experience for physician organizations.

In addition, as we stated in our response to the agency's request for information in April 2017, we encourage CMS to develop a strategy to provide quality information for physician organizations participating in MA.[1] Today, roughly a third of seniors are enrolled in MA and enrollment is expected to continue to grow. These seniors can access information about the quality of their health plan on the plan finder website but no information at the physician organization level is available from CMS. A patient in traditional Medicare can access information about Part B quality on the Physician Compare site, but not information about Part C quality. This omission creates an incomplete picture for beneficiaries who want to access care and an incomplete picture of physician performance, particularly for those physicians who have a large percentage of their patient population in MA rather than traditional Medicare.

Quality data at the physician group level already exists in the MA Stars program. For example, the Integrated Healthcare Association (IHA) has developed a quality ranking program at the physician group level for the state of California. Using MA measures, IHA creates a 5-star quality score for the physician group and publishes the results on the IHA website. We encourage CMS to consider ways to similarly post quality information for physician groups participating in MA.

Finally, we support the addition of a measure to survey physician experiences with MA plans. As CMS notes, physicians are in close contact with health and drug plans on behalf of their patients and on behalf of their own businesses. A survey tool that collects standardized information could be of high value to CMS, physicians, and plans. We encourage CMS to move forward with the development of such a tool and would be pleased to work with CMS to develop meaningful survey questions.

c. CMS should use the 5 Star Quality Ratings program to develop incentives for advanced APM contracting in Medicare Advantage

We call on CMS to use the 5 Star Quality Rating program to differentiate between plans that engage in downstream APM contracts and plans that pay fee-for-service downstream. CMS should develop a MACRA-like incentive for plans and providers that share risk in MA. For example, CMS could add a measure to the Star Ratings program that accounts for the percentage of plan revenue that assumes a two-sided risk arrangement. This would create a bonus on the Part C revenue, which could be shared equally between plan and provider, with CMS paying at least half of the incentive directly to the Part C provider organization. Such an incentive will accelerate the movement from volume to value and is a critical component in transforming the delivery system.

Lastly, as a PACE provider AltaMed asks CMS to reconfirm the continuance of the PACE organization exemption from the Star Ratings when this rule is finalized.

[1] http://capg.org/modules/showdocument.aspx?documentid=3731

Reducing Compliance Program Training Requirements

Existing law specifies that Part C and Part D contracting organizations must have the necessary administrative and management arrangements to have an effective compliance program. There are specific requirements as to what the compliance program must contain, including a requirement that the contracting organization educate first-tier downstream and related entities. These downstream entities have voiced concerns regarding the duplicate requirements across multiple contracting parties and the unnecessary burden associated with these programs. In the proposed rule, CMS is proposing to eliminate the requirement of CMS-developed training for these entities.

AltaMed agrees that many of the current requirements of a compliance program are duplicative and burdensome. Furthermore, we support CMS' decision to eliminate and streamline some of these requirements.

Artificial Limits on Medicare Advantage Plan Variety

Under existing regulations, benefit packages offered in the same area by the same organization may not differ with respect to certain plan characteristics, such as premiums, cost-sharing or benefits.[2] MA plans may submit bids for multiple plans in the same area under the same contract only if the plans are substantially different based on CMS standards. In the rule, CMS proposes eliminating the meaningful difference requirement beginning with MA bid submissions for CY 2019.

AltaMed supports the removal of this requirement to increase competition and innovation, as well as provide beneficiaries with a wider array of choices for their MA plan options.

Flexibility in the Medicare Uniformity Requirement

In the rule, CMS proposes permitting MA organizations to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that all enrollees who meet the specific criteria are treated the same.[3] For contract year 2018, CMS is also considering issuing guidance to clarify flexibility for plans to offer targeted supplemental benefits to certain enrollees.

As a contracted physician organization, AltaMed supports this increased flexibility for MA plans because it will allow us to offer targeted benefits and better meet the needs of our complex and chronically ill patient population.

Updates to the Definition of Marketing

In the proposed rule, CMS proposes to apply some of the current standards and prohibitions related to marketing to all communications and to apply others only to marketing. Marketing and marketing materials would be subject to the more stringent requirements, including the need for submission to and review by CMS. Under this proposal, those materials that are not considered marketing, per the proposed definition of marketing, would fall under the less stringent communication requirements.[4]

AltaMed supports this proposed change to allow for more timely communication with enrollees, while being less burdensome for health plans and by extension, health care providers. As a contracted physician organization, we currently have more flexibility as it relates marketing and marketing materials, when compared to the health plans. This change would extend the same flexibilities to the entire Medicare Advantage industry, making a systematic improvement that will promote efficiency. We are concerned however, with the lack of specific guidelines outlining

[2] Proposed Rule, 422.254(a)(4) and 422.256(b)(4)

[3] Proposed Rule, 422.100(d)

[4] Proposed Rule, 422.2268 and 423.2268

the specific marketing communication materials impacted. As you know, most of the materials provided to beneficiares fall under the maketing category. Though this proposed rule aims to more narrowly define what constitutes marketing, it still remains vague on the specific communication materials that will be deemed "influential" and newly subjected to CMS oversight. We respectfully ask for guidance defining the specific marketing materials that will be impacted.

Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA)

The Comprehensive Addiction and Recovery Act of 2016 (CARA) requires CMS to establish through regulation a framework that allows Part D sponsors to voluntarily implement a drug management program that limits "at risk" beneficiaries' access to controlled substances which CMS determines are "frequently abused drugs" beginning with 2019 plan year.[5] CMS is proposing to incorporate the CARA requirements in the Medicare Part D program.

Currently, PACE organizations are exempted from requirements for drug utilization management, quality assurance, and medication therapy management programs with the understanding that they are either in conflict with or duplicative of PACE requirements, or because the waiver improves PACE organizations' coordination of PACE and Part D benefits. The waivers for the requirement of drug management programs for PACE organizations recognize that, in contrast to insurer-based Medicare Advantage (MA) and Part D Prescription Drug Plans, PACE organizations are provider-based and, as such, relate to their enrollees and are able to manage their drug utilization very differently from other Part D plan sponsors. Generally, PACE participants' prescribers are employed by their PACE organizations, which monitor each participant's care, including the use of prescription drugs, directly and on a regular basis. If participants' prescribers are not employed by the PACE organizations themselves, e.g. in cases where a PACE organization utilizes contracted community-based primary care physicians, PACE programs utilize relatively small networks of contracted physicians who interact on a regular basis with participants' interdisciplinary teams.

As a PACE Organization and a member of the National PACE Association (NPA), we ask CMS to confirm that the rule excludes PACE organizations' waivers for Part D requirements. In addition, we request that existing waivers be extended to include a requirement for the drug management program unless such a waiver is not needed due to the voluntary nature of the drug management program.

Default Enrollment

Under current law, the Secretary of HHS has authority to implement default rules for the MA program in addition to the statutory direction that beneficiaries who do not elect an MA plan are defaulted to traditional Medicare.[6] In this proposed rule, CMS proposes to codify requirements for seamless default enrollments for certain Medicaid managed care enrollees who become eligible for Medicare. The defaults would be into dual eligible special needs plans (D-SNPs) and would be subject to five conditions: (1) the individual is enrolled in an affiliated Medicaid managed care plan and is dually eligible; (2) the state has approved use of the default enrollment process and provided Medicare eligibility information to the MA organization; (3) the individual does not opt out; (4) the MA organization provides the individual a notice that meets CMS requirements; and (5) CMS has approved the MA organization to use default enrollment before any enrollments are processed.[7] CMS also proposes to establish a

[5] Centers for Medicare and Medicaid Services. (November 16, 2017). *CMS Proposes Policy Changes and Updates for Medicare Advantage (MA) and the Prescription Drug Benefit Program (CMS-4182-P).* Retrieved from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-16.html?_cldee=c3JvYmluZXR0ZUBjYXBnLm9yZw%3d%3d&recipientid=contact-dead4a3ca5ede61180ecc4346bac7b90-b5e15fc126d8400e8e89f4e9929dc902&esid=3432a78b-a2cb-e711-8116-e0071b6a10b1

[6] Proposed Rule, *422.66 and 422.68*

[7] Proposed Rule, 422.66(c)(2)

new, simplified *opt-in* election process for all MA organizations for the MA enrollments of their non-Medicare members (including commercial and Medicaid).[8]

AltaMed supports the use of default enrollment for enrollees transitioning from Medicaid managed care into D-SNPs. This change will increase the enrollment of dually eligible individuals into a fully integrated system of care and will improve health outcomes. AltaMed congratulates CMS on their commitment to simplifying enrollment for MA beneficiaries, but do ask that information is provided to these beneficiaries regarding all their options, including PACE. We believe it is important for our most vulnerable and medically high need patients to be informed regarding all their options in order ensure the best possible care.

Passive Enrollment Opportunities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries

Current passive enrollment authority limits the use of passive enrollment to instances where there is immediate termination of an MA contract and when CMS determines remaining in a plan poses harm to beneficiaries. In this proposed rule, CMS will expand this authority to allow passive enrollment for full-benefit dually eligible beneficiaries from a non-renewing integrated D-SNP to another comparable plan to preserve care integration under certain circumstances.

AltaMed supports this proposed change to assure continuation of care for this high need population and create an opportunity for an increased enrollment of dually eligible individuals into managed care plans. However, we ask CMS once again, to provide information to these beneficiaries regarding all their options, including PACE. Both Managed care plans and the PACE program offer high-quality integrated care and cost savings across the board.

Limitation to the Part D Special Enrollment Period for Dual and Other LIS-Eligible Beneficiaries

CMS is proposing to change the Special Election Period (SEP) for dual-eligible and LIS beneficiaries from an open-ended monthly SEP to one that may be used only in the following circumstances (and only if the beneficiary has not been identified as potentially at-risk or at-risk): (1) within a certain period of time after a CMS or State-initiated enrollment; or (2) as a onetime annual opportunity that can be used at any time of the year. The proposed rule would establish a separate SEP that can be used by any dual or other LIS-eligible beneficiary, including those who have been identified as potentially at-risk or at-risk, within a certain period of time after a change to an individual's LIS or Medicaid status. [9]

AltaMed supports NPA's comments and also seeks CMS' assurance that the limitation of SEPs for dually eligible and other low-income subsidy eligible beneficiaries as proposed, will not in any way limit PACE-eligible Medicare beneficiaries' ability to enroll in a PACE organization continuously throughout the year. We believe continuous access to PACE supports CMS' interest in promoting beneficiaries' access to fully integrated, coordinated Medicare and Medicaid benefits. Conversely, we want to ensure that CMS' proposed changes would not limit the ability of a Medicare beneficiary disenrolling from PACE to access a PDP or MA-PD continuously throughout the year.

Restoration of the Medicare Advantage Open Enrollment Period

From 2007 to 2010, MA-eligible individuals had a one-time opportunity to make an enrollment change between January 1 and March 31. This "old" open enrollment period allowed new enrollment into an MA plan from traditional Medicare, switches between MA plans, and disenrollment from MA to traditional Medicare. In 2010, the Affordable Care Act (ACA) eliminated the old OEP and instead provided a different enrollment period for enrollees to leave MA for traditional Medicare in the first 45 days of the year. The 21st Century Cures Act modified

[8] Proposed Rule, 422.66(d)(5)

[9] Ibid., Centers for Medicare and Medicaid Services

the statute to create a new open enrollment period from January 1 to March 31 each year. The new OEP allows a one-time election during the first three months of the calendar year to switch MA plans or to disenroll from MA into traditional Medicare.

Individuals with enrollment in traditional Medicare are not able to use the new OEP to enroll in an MA plan. The proposed rule also states that organizations will not be allowed to market during this new enrollment period.

AltaMed supports the restoration of the Medicare open enrollment period because it assists to facilitate enrollment in Medicare Advantage. However, we are concerned that even though this rule will add flexibility for beneficiaries it does not provide an additional marketing opportunity for health plans or for contracted providers. We request that CMS oversee and set guidelines for brokers during this new open enrollment period. Lastly, as a PACE organization we ask CMS to confirm that the PACE SEP will continue to allow MA and Part D enrollees to disenroll from an MA plan, an MA-PD or a standalone PDP at anytime throughout the year to enroll in PACE. Conversely, PACE participants may disenroll at any time throughout the year and access MA, MA-PD and PDP options.

Preclusion List Requirements for Prescribers in Part D and Providers and Suppliers in Medicare Advantage, Cost Plans, and PACE

CMS proposes eliminating the prescriber and provider enrollment requirement and compiling a "Preclusion List" of individuals and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under a reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Under this option, CMS would make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans would then be required to deny claims from or written by prescribers and providers on the list. [10]

AltaMed appreciates CMS' consideration of this alternative to the enrollment requirement because it creates less burden for us as Prescribers in Part D, Medicare Advantage Providers, and as a PACE organization. However, we support NPA's comments and ask for further clarification on various elements that directly affect PACE organizations. We refer you to NPA's comments dated January 10, 2018.

AltaMed appreciates the opportunity to share our comments regarding the proposed policy changes and updates for Medicare Advantage, the Prescription Drug Benefit Program and the PACE Program. Should you have any questions, please feel free to contact me at bconstant@altamed.org or 323-558-7716.

Sincerely,

Berenice Nuñez Constant, MPH
Vice President
Government Relations

[10] Ibid., Centers for Medicare and Medicaid Services