National Council on Aging

March 5, 2018

Demetrios Kouzoukas
Director, Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies, and 2019 Call Letter

Dear Mr. Kouzoukas:

The National Council on Aging (NCOA) appreciates the opportunity to comment on the 2019 call letter. The National Council on Aging (NCOA) is one of the nation's leading nonprofit service and advocacy organizations representing older adults and the community organizations that serve them. Our goal is to improve the health and economic security of 10 million older adults by 2020.

Section I – Parts C and D

Annual Calendar

As in prior years, CMS indicates that MA and Part D plans should disseminate both the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) by September 30th. We continue to encourage CMS to revisit its prior recommendation, which was proposed most recently in the proposed Part C and D rule, to require separate mailings of the ANOC and EOC for MA plans. This practice would be similarly beneficial for Part D plans. The EOC is long and detailed, and many beneficiaries do not understand it, or even read it fully. By contrast, the ANOC is a shorter, more streamlined tool and, more importantly, it is time sensitive.

At the same time, improvements to the ANOC are long overdue. We continue to advocate for an individualized MA and Part D ANOC to better serve beneficiary needs, specifically one that details which specific providers are leaving a plan network, which specific prescription drugs are no longer on the plan formulary, and where utilization management tools will be newly applied. Ideally, these customizations should reflect an enrollee's actual providers, services, and prescription drugs since the plan has the data and capacity to provide this individualized information.

We strongly urge CMS to consider opportunities to tailor these notices to individual information needs. At a minimum, we suggest that CMS solicit input from multiple stakeholders on recommendations to improve the ANOC, EOC, and other standardized materials used during the annual election period.

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Enhancements to the 2019 Star Ratings and Future Measurement Concepts

NCOA supports CMS' proposal to establish a Technical Expert Panel (TEP) in 2018 comprised of representatives across various stakeholder groups to obtain feedback on the star ratings. The TEP should include strong representation from beneficiary advocates.

Removal of Measures from Star Ratings

NCOA is disappointed by CMS' proposal to retire the current Beneficiary Access and Performance Problems (BAPP) measure, and revise it to only focus on Compliance Activity Module (CAM) data. While CAM data is useful, the measure should also continue to be based on sanctions and civil monetary penalties (CMPs).

As we have noted in previous call letters, we urge CMS to strengthen the connection between Star Ratings and audits. The integrity of the Star Ratings and the ability of the ratings to aid in the selection of a plan must not be compromised. This means that Star Ratings must reflect the severity of issues that result in a plan being sanctioned. For example, CMS sanctioned Cigna in 2016 for a "longstanding history" of noncompliance, in which they threatened the health and safety of beneficiaries. Yet, despite these major issues, Cigna did not receive a reduction in Star Ratings, and therefore received a quality bonus payment – which is incongruent with their major compliance problems that impacted beneficiaries. When CMS sanctions a contract, the contract has significant issues which should be apparent to Medicare beneficiaries in the Star Ratings when shopping for plans. We therefore encourage CMS to reconsider its stance to remove all connection between this star rating and sanctions and CMPs.

Reducing the Risk of Falling Measure Temporarily Removed

We urge CMS to retain the measure "Reducing the Risk of Falling" in the Star Ratings for 2019 and 2020. NCOA leads the U.S. Administration for Community Living-funded National Falls Prevention Resource Center, which supports awareness and educational efforts about falls and promotes evidence-based falls prevention programs and strategies across the nation. While we understand the need to update the measure given the changes in the underlying survey questions, removing the measure altogether for two years is unnecessary and harmful to beneficiaries. It is crucial beneficiaries understand and have access to adequate falls prevention options through their health plans. Falls result in more than 2.8 million injuries treated in emergency departments annually, including over 800,000 hospitalizations and more than 27,000 deaths. Additionally, costs for older adult falls are estimated to be over $31 billion annually; most of these costs are paid for by Medicare. However, many falls can be prevented with proper screening, assessment, referrals, and intervention, such as evidence-based falls prevention programs and protocols.

This measure holds plans accountable for working towards a reduction in the risk of falls. Without the measure, beneficiaries lack any indication of how much attention falls prevention receives under different plans, and plan incentives to reduce the risk of falls would be weakened. Performance on the measure has consistently declined in the past few years, and it is important that beneficiaries and those who represent and assist them

see where plans may be lacking in this area. Removing the measure, even for two years, could send the wrong message to plans and beneficiaries – that preventing falls is not important and does not need to be measured, and that plans will not be held accountable for their performance in this area. NCOA strongly encourages CMS to keep the measure in the Star Ratings for 2019 and 2020 while the measure is being updated, to allow beneficiaries consistent knowledge of how plans perform in falls reduction and continue to hold plans accountable.

Proposed Scaled Reductions for Appeals IRE Data Completeness Issues
In an expansion of data integrity efforts, CMS is proposing to reduce a contract's Part C or Part D appeals measures' star ratings when independent review entity (IRE) data are not complete or otherwise lack integrity. The proposal calls for a sliding scale methodology based on severity of data integrity, whereby a contract could be penalized with a 1 star to 4 star reduction. We strongly support this proposal.

Validation Audits
CMS notes that it "currently requires sponsoring organizations that have more than five program audit conditions in their final audit report to hire an independent auditing firm to conduct a validation audit. CMS conducts the validation audits of sponsoring organizations that fall below this threshold. We are seeking comments on whether this threshold should be increased or decreased, or limited to conditions that may cause adverse impacts to beneficiaries."

While we support requiring plans to hire independent auditors to conduct validation audits, we urge CMS to revisit the agency's prior proposal to increase audit and inspection authority. In a 2015 proposed rule, CMS details the criteria by which it determines which MA and Part D plan sponsors are audited each year and acknowledges that limited resources allow the agency to perform annual audits on only 10% of plan sponsors—30 of 300. CMS previously proposed, but chose not to finalize, a rule requiring plan sponsors to hire independent auditors. Given that audit results repeatedly reveal significant problems with sponsor performance in various areas (particularly appeals and grievances), it is important that audits are done effectively and lead to enforcement actions. We therefore ask CMS to revisit its proposal to require plans to hire independent auditors.[1]

Plan Finder Civil Money Penalty (CMP) Icon or Other Type of Notice
NCOA supports CMS' proposal to establish a Plan Finder Civil Money Penalty (CMP) icon or other type of notice. Similar to the Plan Finder icon for plans under sanction, this is a positive change that will foster transparency, and give beneficiaries more complete information about their plan options when shopping.

We also note that CMS proposes "regular updates" throughout the year. We strongly endorse an approach that updates enforcement actions in real time rather than the current practice of bunching releases of CMPs in February after the annual Open Enrollment Period has ended. Beneficiaries are asked to make market-based enrollment decisions

[1] 80 Fed Reg 7919 (February 12, 2015).

during the OEP and, for those with Special Enrollment Periods, throughout the year. They need full transparency so that they know all the available information about a plan's performance, and they need it in time to make informed decisions. We acknowledge that not every plan sponsor is audited every year and that some monetary penalties are relatively small but these facts do not override the importance of beneficiaries to have timely access and to make their own judgments in evaluating information that is undeniably relevant to health care choices.

Enforcement Actions for Provider Directories

CMS indicates that the agency has authority to impose enforcement actions against sponsors that are egregiously non-compliant and have inaccurate provider directories, but does not indicate any specific plans to conduct harsher oversight on sponsors with inaccurate provider directories. NCOA strongly encourages CMS to take direct action against sponsors with inaccurate provider directories. As CMS discovered in their own review, there are significant inaccuracies across provider directories.[2] These issues merit CMS enforcing accurate provider directories with all sponsors, rather than only imposing enforcement actions on those sponsors who are egregiously non-compliant when audited.

Section II – Part C

Meaningful Difference (Substantially Duplicative Plan Offerings)

As noted in our comments on the proposed changes to Medicare Parts C and D, NCOA is concerned by CMS' proposal to eliminate the meaningful differences requirement for Medicare Advantage (MA) plans. Beneficiaries already face complex choices when shopping for an MA plan – on average, beneficiaries have a choice of 21 MA plans. In 206 counties, beneficiaries chose from among more than 30 plans for the 2018 plan year.[3] Beneficiaries are more likely to enroll in plans when presented with fewer choices. In multiple studies, beneficiaries had higher rates of enrollment in Medicare Advantage plans when presented with 15 or fewer plans. Empirically, more choice may be detrimental if there are too many or overly complex options, particularly in high-stakes decisions that involve health or money. Beneficiaries may choose inferior options or make no choice at all as a result of cognitive overload, anticipated regret, or bias toward the status quo.[4,5]

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[2] Center for Medicare and Medicaid Services. Online Provider Directory Review Report. Available at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf

[3] Jacobson, G, Damico, A., and Neuman, T. Medicare Advantage 2018 Data Spotlight: First Look. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-spotlight-first-look/

[4] *The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help Consumer Decision Making;* Lynn Quincy and Julie Silas; Consumers Union, November 2012 (http://consumersunion.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf)

[5] *Cognitive Functioning and Choice between Traditional Medicare and Medicare Advantage;* J. Michael McWilliams, Christopher C. Afendulis,, Thomas G. McGuire, and Bruce E. Landon; Health Affairs, September 2011 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513347/)

Although a great deal of information is available, beneficiaries often have difficulty understanding its significance and using it correctly to make decisions. Most beneficiaries have difficulty correctly interpreting even simple displays of Medicare health plan information.[6] NCOA recently conducted a series of in-person beneficiary interviews in which beneficiaries shopped for a plan on Plan Finder, and provided feedback for a report on Medicare Plan Finder, to be released in March 2018. Most beneficiaries interviewed showed little or no health literacy. For example, many beneficiaries superficially understood that copays, coinsurance, and deductible represent out-of-pocket costs, but could not indicate any more about how these types of cost-sharing differed from each other. Thus, beneficiaries were unable to compare plans successfully that had differences in these factors.

Before CMS even considers repealing the meaningful differences requirement, it is crucial to prioritize comprehensive updates to beneficiary tools, such as Medicare Plan Finder. In addition to highlighting the inadequacies of the provider directories, beneficiaries interviewed by NCOA also expressed frustration about other parts of the website, including layout, display, the lack of personalized costs, and the inability to use the website to compare Medicare Advantage with the option of Original Medicare and Medigap.

At the same time as previously noted in our comments, improvements to the ANOC are long overdue. We continue to advocate for an individualized MA and Part D ANOC to better serve individual beneficiary needs, specifically one that details which specific providers are leaving a plan network, which specific prescription drugs are no longer on the plan formulary, and where utilization management tools will be newly applied. Ideally, these customizations should reflect an individual's actual providers, services, and prescription drugs.

We strongly urge CMS to consider opportunities to tailor these notices to individual information needs. At a minimum, we suggest that CMS solicit input from multiple stakeholders on recommendations to improve the ANOC, EOC, and other standardized materials used during the annual election period. CMS' commitment to stakeholder input through the comment process for the Welcome to Medicare packet in 2017 was an example of a potential process for modernizing other Medicare notices. It is important to improve all beneficiary decision aids, including mailings and 1-800-MEDICARE, so beneficiaries can more easily use them to understand their choices when shopping for Medicare plans.

At a minimum, instead of completely repealing the meaningful differences requirement, CMS should propose an alternative test of meaningful differences that may address concerns from plans. For example, CMS could work with stakeholders to develop a test

[6] *Medicare Advantage: Options for Standardizing Benefits and Info to Improve Consumer Choice;* Ellen O'Brien and Jack Hoadley; The Commonwealth Fund, April 2008 (http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2008/Apr/Medicare%20Advantage%20%20Options%20for%20Standardizing%20Benefits%20and%20Information%20to%20Improve%20Consumer%20Choice/OBrien_Medicare_Advantage_options_1117_ib%20pdf.pdf)

that incorporates differences in benefit structure. CMS could also allow plans to seek waivers by providing alternate evidence of meaningful differences. For example, CMS could require that if the current meaningful difference standard were not met, plan sponsors would have to provide stronger evidence that beneficiaries would be able to easily distinguish between the sponsor's offerings. Applying the meaningful difference standard as leverage would provide CMS with tools to address any confusion.

Part C Optional Supplemental Benefits

We are hopeful that the broader definition of health related supplemental benefits proposed in the call letter will help to appropriately meet member needs and prevent avoidable injury or illness. We expect that, for example, there are many frail plan members who would benefit greatly from falls prevention devices but who do not otherwise require intensive care coordination, a requirement of the chronically ill enrollee definition.

While we are supportive of the proposed changes, we ask CMS to closely monitor their implementation to determine the extent to which the benefits are actually offered and utilized and to ensure that implementation is not directly or indirectly discriminatory. Tracking of benefits and outcomes also will allow CMS to evaluate the efficacy of particular supplemental benefits.

The twin issues of appropriate marketing restrictions and adequate beneficiary education on the availability of the benefit need to be carefully addressed. We ask CMS to involve stakeholders in working out those details. Beneficiaries also need full appeal rights for all denials of supplemental benefits.

Additionally, CMS should give beneficiaries of Traditional Medicare the same access to items and services which diminish the impact of health conditions and reduce avoidable utilization. CMS shouldensure that effective interventions are equally available to all beneficiaries without regard to how they choose to receive their benefit.

Medicare Advantage Uniform Flexibility

As noted in our comments on the proposed changes to Medicare Parts C and D, NCOA has concerns with the proposal to increase flexibility in the Medicare Advantage Uniformity requirements. Loosening uniformity requirements in the manner CMS proposes could – by itself -- create a chaotic environment for Medicare beneficiaries trying to make informed decisions about what options might be best for themselves.

We are also concerned about the limited public notice and comment opportunity surrounding this significant change in policy. Unlike the proposed change to MA meaningful difference requirements, discussed above, about which CMS states it is still reviewing comments to the proposed Part C and D rule issued in November 2017, CMS presents its new interpretation of MA uniformity requirements in the draft Call Letter as if it is final policy, without consideration of comments to the proposed C and D rule wherein CMS first articulates and solicits feedback on this policy change. We note that approximately two weeks transpired between the end of the comment period to the

proposed rule and the issuance of the draft Call Letter – January 16 to February 1, 2018. This would have left minimal time to review and incorporate public comment to this change in policy.

Despite presenting a final policy change effective for plan year 2019, CMS does not offer meaningful guidelines concerning the scope of this proposal, does not outline marketing guidelines to ensure that plans don't mislead prospective enrollees with promises of specially-tailored benefits, and does not present thoughtful approaches to beneficiary education about a policy change that will make plan comparison much more difficult. Instead, in the draft Call Letter, CMS merely offers a "special mailbox" following issuance of the Final Call Letter for plans that have questions about whether a proposed targeted supplemental benefit is allowable.

Should CMS choose to proceed with increasing flexibility in these requirements, it must, at a minimum, include basic consumer protections and oversight included in the value-based insurance design (VBID) demonstration, which began in January 2017. When CMMI first proposed a VBID demonstration, beneficiary advocates provided extensive feedback. The resulting demonstration model reflects careful consideration of many important beneficiary protections. Beneficiary protections that CMS must establish include:

- conditions of participation for plans – plans under sanction and plans with below-average star rating should not be permitted increased flexibility;
- utilization of only positive reinforcement in the form of lowered cost-sharing and expanded benefits, rather than discouragement of lower-value services (in other words, "carrots" vs. "sticks");
- limit approval of lower cost-sharing only to instances where there is a well-established evidence-base that illustrates a particular service, prescription medication, or health care provider is in fact "high-value." We also encourage CMS to develop a standardized list of health care services or prescription drugs that may be subject to altered cost-sharing in consultation with clinicians and other experts;
- evaluation and monitoring: enrollee protections, like marketing prohibitions, are ineffective and without force unless compliance is monitored and enforced.
- establish a clear strategy and requirements for health care provider and beneficiary education and outreach.
- Transparent evaluation and outcomes: We urge CMS to publish annual reports highlighting how the increase in flexibility affects beneficiaries, if CMS proceeds with this proposal.

Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs

Integrated Model Materials:

We appreciate and support the efforts of CMS to create better and more integrated models of the summary of benefits, the ANOC and provider and pharmacy directories. In designing model documents, we ask that CMS:

- Use plain language and a reading level no higher than sixth grade;
- Consumer test all documents;
- Use the translation standards that promote the greatest access. As was done in the Memorandums of Understanding (MOUs) in the financial alignment demonstration, where Medicare and Medicaid standards for translation and alternate formats differ, apply the standard providing the greatest access to individuals with disabilities or limited English proficiency.[7] Dual eligibles who are accustomed to receiving communications about their Medicaid benefits in a language or format they can understand should not have to face the challenge of receiving information from their D-SNP that they cannot understand or use;
- Tailor the notices to the individual's circumstances and include only information directly relevant to the purpose of the notice.

We also ask that CMS continue to work to improve other dual eligible-specific notices beyond those listed in the Call Letter and, more generally, to tailor all its notices to the specific circumstances of the beneficiary.

We recognize that creating clear notices to explain complicated programs presents challenges and would be pleased to work with CMS on this ongoing effort.

Part A and B Cost Sharing for Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

We appreciate that CMS continues its efforts to obtain full plan compliance with requirements to protect QMBs from improper billing. We also particularly thank CMS for the steps it has taken to make identification of QMBs easier for providers through the HETS system.

CMS' efforts have brought broader understanding of QMB protections and more responsiveness by plans when problems arise. The situation is improving but challenges persist. Some plan providers still do not understand the protections or are unwilling to honor them some plan representatives still do not understand or fulfill their obligations to protect members. Thus, we believe that CMS's continued emphasis in this Call Letter on plan obligations to educate providers and to give them the tools to identify QMBs is fully warranted. Further, we ask that CMS monitor Complaint Tracking Module (CTM) entries

[7] *See, e.g.*, "Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) and The State of California Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrolless," p. 16 (last visited March 1, 2018), cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf.

to identify plans and plan sponsors that have repeated complaints in order to focus education and enforcement.

Section III – Part D

Two Drugs Per Category and Class/Protected Classes:
We strongly support the existing policy requiring all Part D sponsors to cover 2 drugs per category and class and all drugs within the 6 protected therapeutic classes of clinical concern. Altering these protections could lead to overly restrictive formularies that could limit beneficiary access to vital, life-saving medications. Moving forward, we ask that CMS keep these formulary requirements intact and maintain a rigorous review process.

Tier Composition
In discussing tiering structures, CMS states that the agency continues to believe that a coinsurance structure is the preferable cost-sharing structure for the non-preferred drug tier. NCOA requests that CMS release its data analysis that supports this finding. From the beneficiary point of view, we question the value to the beneficiary of a coinsurance structure for any tier. While a coinsurance structure might support reasoned plan selection if drug prices were predictable and constant, the unfortunate fact is that they are not. Plan Finder listing of drug prices can change as frequently as every two weeks and sometimes those changes are dramatic. Moreover, the relative price of a drug in their plan versus other plans can also change significantly. Thus, with a coinsurance structure, beneficiaries have no way to predict their payment liability when choosing a plan or to predict whether the plan they have chosen will continue to be the most appropriate for their needs over the course of the plan year. When beneficiaries can compare plans with set co-payments, they are much better able to make informed market-based choices and budget for their health care needs.

We also request that CMS remain diligent in its monitoring of formulary structure. NCOA remains concerned about increasing beneficiary costs for generic drugs. In particular, we are concerned that, by adopting a non-preferred drug tier, CMS is tacitly accepting the shift toward coverage for generic drugs undistinguishable from brand drug coverage. The non-preferred drug tier often includes numerous generic drugs. As a result, generic drug cost-sharing artificially increases lower average cost-sharing for the tier, allowing plans to achieve higher cost-sharing for high-cost brand drugs. We strongly believe that CMS must maintain its rigorous monitoring of this tier and ensure that cost-sharing does not exceed negotiated price.

Specialty Tiers
NCOA is concerned that, like many previous plan years, the specialty tier threshold is stagnant and does not take into consideration the effects of inflation on drug prices or, especially, the growing number of high-cost specialty drugs. Beneficiaries typically face higher out-of-pocket costs for specialty tier drugs because plans are more likely to require patients to pay a coinsurance rate for incredibly expensive drugs rather than a flat copayment in order to access these drugs. Keeping the specialty tier threshold low means

that more drugs fit into this tier, which raises costs for Part D plan enrollees, makes it harder for them to afford needed medications and limits access to the tiering exception.

We encourage CMS to take additional steps to protect beneficiaries from unmanageable financial distress, which sometimes occurs when beneficiaries diagnosed with chronic or life-threatening diseases must rely on critical specialty medications. First, NCOA strongly urges CMS to formally require that the specialty tier threshold be increased by, at a minimum, the same rate of growth as the Part D benefit parameters. This will set an important precedent that should serve as a foundation for a more dynamic specialty tier policy in future years.

We urge CMS to establish a cost-sharing exception and appeal process for drugs included on the specialty tier. The issue remains exceptionally important for beneficiaries with conditions that have limited treatment options (ie, when all of the therapeutic options fall under the specialty tier and its equivalent higher cost-share for beneficiaries). For all other plan formulary tiers, beneficiaries may file an exception for a drug to be placed on a lower cost-sharing tier, provided that the medication is the only therapy available for their disease. Specialty tier drugs are the sole exception to this, despite the fact that these drugs often having the most burdensome cost-sharing requirements. We encourage CMS to reconsider this policy and implement an exception and appeal process for the specialty drug tier at the earliest possible time.

Thank you again for this opportunity to share our comments. If you have any questions or if we can be of any further assistance, please contact Samantha Zenlea at Samantha.Zenlea@ncoa.org.

Sincerely,

Samantha Zenlea
Senior Regulatory Policy Specialist