Center for Medicare Advocacy
MedicareAdvocacy.org

March 5, 2018

Via Electronic Submission to www.regulations.gov

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, Maryland 21244

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 Administrator Verma:

The Center for Medicare Advocacy (Center) is pleased to provide the Centers for Medicare & Medicaid Services (CMS) comments on the draft 2019 Call Letter. The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

General Comment re: Medicare Advantage Payment

We recognize that the payment methodologies outlined in the Advance 2019 Rate Notice and Call Letter are consistent with applicable law, particularly the Affordable Care Act (ACA) changes to bring Medicare Advantage (MA) plan payments in line with costs under the traditional Medicare program. The Center continues to support this effort to achieve this payment parity, both as a matter of equity between MA and traditional Medicare, and as a means of appropriately safeguarding public funds.

Despite much attention given to the annual rate notice concerning MA payment, though, we urge CMS to direct more attention to protecting public funds by ensuring that such payment is accurate. Various studies have attempted to document the scale of inappropriate MA coding intensity, or upcoding, and the resultant overcharges by MA plans. An investigation by the Center for Public Integrity, for example, found that Medicare paid MA plans nearly $70 billion in "improper" payments, mostly from upcoding, from 2008 through 2013 alone.[1] More recently, a study published in *Health Affairs* found that coding intensity practices could result in overpayments to MA plans totaling $200 billion over the next decade.[2] According to MedPAC, "after accounting for all coding adjustments, payments to MA plans were about 4 percent higher than Medicare payments would have been if MA enrollees had been treated in [traditional] Medicare."[3]

In April 2016, the General Accounting Office (GAO) issued a report entitled "Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments."[4] The report states that CMS estimates that about 9.5% of its annual payments to Medicare Advantage (MA) organizations were improper – totaling $14.1 billion in 2013 alone – "primarily stemming from unsupported diagnoses submitted by MA organizations." The report also highlights the significant flaws in CMS' current efforts to address and recoup such payments, including execution of the Risk Adjustment Data Validation (RADV) audit process.

The Center is deeply concerned by these ongoing improper payments to MA plans and CMS' lack of progress in recouping previous payments and deterring future misconduct. In order to ensure that the traditional Medicare program is not further disadvantaged by inappropriate overpayments to MA plans, CMS must employ more rigorous oversight of MA payment.

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[1] See, e.g., Center for Public Integrity, "Why Medicare Advantage costs taxpayers billions more than it should" (June 2014), available at: https://www.publicintegrity.org/2014/06/04/14840/why-medicare-advantage-costs-taxpayers-billions-more-it-should. See, also, Center for Public Integrity, "Medicare Advantage audits reveal pervasive overcharges" (August 2016), available at: https://www.publicintegrity.org/2016/08/29/20148/medicare-advantage-audits-reveal-pervasive-overcharges?utm_source=email&utm_campaign=watchdog&utm_medium=publici-email&goal=0_ffd1d0160d-631decf34e-100055089&mc_cid=631decf34e&mc_eid=52f7afd44e.

[2] Kronick, R., "Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By $200 Billion Over Ten Years," (Health Affairs: February 2017), available at: http://content.healthaffairs.org/content/36/2/320.abstract.

[3] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy (March 2017), Chapter 13, p. 367, available at: http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0.

[4] GAO, "Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments" (April 2016), available at: www.gao.gov/assets/680/676441.pdf.

Attachment II. Changes in the Part C Payment Methodology for CY 2019

G. Medicare Employer Retiree Plans

CMS is proposing to complete the transition to administratively set rates for Medicare Advantage Employer Group Waiver Plans (EGWPs) that was originally scheduled to be completed in 2018. In order to ensure greater payment equity between EGWPs and non-EGWP MA plans, we support this proposal, and urge CMS to not delay in fully implementing the alternative payment policy for MA EGWPs.

K. Medicare Advantage Coding Pattern Adjustment

As noted above, inappropriate Medicare Advantage coding intensity – upcoding – is a problem that must be addressed. We recommend CMS increase the coding intensity adjustment for 2019 above the proposed level of 5.90 percent — the statutory minimum. As MedPAC found in its March 2016 report to Congress, the statutory minimum coding adjustment is highly insufficient to fully offset current coding intensity trends.[5] In its March 2017 Report to Congress, MedPAC noted that its "updated analysis shows that higher coding intensity has resulted in MA enrollees having risk scores that were about 10 percent higher than scores for similar FFS beneficiaries, an increase over [the previous] year."[6]

We also continue to encourage CMS to ensure that at-home risk assessments show services for MA enrollees that are meaningful and effective for beneficiaries' clinical condition(s). There is a continued risk that such assessments provide a vehicle for collecting diagnoses, without guaranteeing that there is meaningful follow-up care, and attendant payment increases that do not reflect meaningful differences in risk or the provision of care.

Attachment VI. Draft CY 2019 Call Letter

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. The Center supports the proposal in the recent Part C and D rule to separate the mailings of the Annual

[5] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2016, http://medpac.gov/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report-.pdf?sfvrsn=0.

[6] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2017, pp. 347-348, http://medpac.gov/docs/default-source/reports/mar17_entirereport224610adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.

Notice of Change and Evidence of Coverage for MA plans, and hope that this proposal is finalized. 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 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.

Enhancements to the 2019 Star Ratings and Future Measurement Concepts

The Center appreciates CMS' stated objective of ensuring that the Star Ratings system accurately reflect plan quality and enrollee experience. Comments on specific measures are outlined below.

Beneficiary Access and Performance Problems (BAPP)(Part C &D) Measure Removal

We are concerned about the proposal to remove the Beneficiary Access and Performance Problems (BAPP) measure from the Star Rating system.[7] We are troubled that the new measure will only take into account notices of non-compliance, warning letters and ad-hoc corrective action plans, without including sanctions and civil money penalties. We believe that decoupling audits and enforcement actions from the Star Ratings undermines the integrity of the Star Ratings system.

We urge CMS to ensure that the Star Rating system does not mask or otherwise minimize plan conduct that puts Medicare enrollees at risk. Particularly when CMS finds that a plan's conduct poses a serious threat to the health and safety of Medicare beneficiaries, that finding must have an impact on overall ratings.

Perhaps the most glaring disconnect is when a plan is identified as having the same, repeated serious deficiencies in audit scores while its Star Ratings continue to rise. To address this imbalance, it is critically important that Star Ratings incorporate audit measures and reflect audit

[7] Our detailed comments on the BAPP measure from the 2018 Call letter are available at: http://www.medicareadvocacy.org/center-comments-on-draft-2018-medicare-advantage-call-letter/.

results in meaningful ways, while CMS continues to impose significant sanctions and penalties when serious deficiencies are identified. When CMS sanctions a contract, the contract has significant issues that should be apparent to Medicare beneficiaries in the Star Ratings when shopping for plans.

CMS has stated that the integrity of the Star Ratings and the ability of the ratings to aid in the selection of a plan must not be compromised. In order to ensure that the Star Ratings are able to serve as the tool they claim to be, the ratings must reflect the severity of issues that result in a plan being sanctioned. We believe that only including notices of non-compliance, warning letters and ad-hoc corrective action plans is insufficient. We recommend that CMS reconsider significantly weighting the BAPP measure and/or adjusting the overall and summary Star Ratings by at least one star for sanctioned plans.

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. 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. We strongly encourage 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.

Data Integrity

We support CMS' data integrity policy, and agree with CMS that "[g]iven the financial and marketing incentives associated with higher performance in Star Ratings, safeguards are needed to protect the Star Ratings from attempts to inflate performance or mask deficiencies" (pg 114).

In keeping with CMS' stated aim to provide accurate information to beneficiaries in a transparent manner, we would like to express support for a specific policy that is longstanding regarding data integrity. We reiterate the support we expressed in the recent C and D rule regarding regulations proposing to codify the existing policy of reducing a contract's measure rating if CMS determines that the measure data are incomplete, inaccurate, or biased.[8] We agree with CMS that without such ramifications, gaming the Star Ratings would be possible. We support CMS in developing this safeguard. Without accountability and accuracy the Star Ratings system would be, at best, meaningless for beneficiaries, and dangerously misleading at worst. We appreciate this effort and urge CMS to vigorously enforce this policy and practice vigilant oversight in this area.

Proposed Scaled Reductions for Appeals IRE Data Completeness Issues

In an expansion of this data integrity, CMS is proposing to reduce 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.

2019 Star Ratings Program and the Categorical Adjustment Index

We would like to emphasize that we support quality ratings that accurately reflect quality of care, and reiterate our concerns about any changes to quality measurement that allow a plan's quality rating to increase without any changes in the quality of care.[9] We are concerned that this will mask disparities in care without addressing the poor care that disadvantaged patients disproportionately receive.

We strongly support CMS in seeking to utilize the Star Rating system to encourage continuous quality improvement in the MA and Medicare Prescription Drug programs, providing oversight

[8] Our detailed comments to the Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2019 are available at: http://www.medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/.

[9] Our detailed comments regarding risk adjustment in Star Ratings are available: http://www.medicareadvocacy.org/center-comments-on-medicare-advantage-part-c-and-part-d-payment-policies/.

to ensure accuracy and transparency, and not accepting any changes to performance measurement that would lead to masking disparities and harming disadvantaged patients.

We continue to express concerns regarding the Categorical Adjustment Index (CAI) used as a method of risk adjustment for within-contract disparity in performance based on LIS/dual eligible status, precisely because it may result in masking disparities in care. We understand that there are real differences in care for harder to reach populations -- we agree that disparities in care exist. However, we do not support adjusting Star Ratings for care that continues to be subpar. If a Star Rating is inflated because of the population being served, without making any changes to the care that population is receiving, then the Star Ratings become meaningless. This is evidenced by the statement in the Call Letter that most of the contracts had their Star Ratings increase as a result of the CAI, with only a few decreasing. "For the 2018 Star Ratings, the impact of the CAI resulted in primarily positive movement of the ratings." (pg 125). It seems that those contracts had their Star Ratings increase without improving care for LIS/dual enrollees.

We urge CMS to examine the beneficiary impact of any changes to Star Ratings, and develop a plan to ensure disparities will not be masked or exacerbated. CMS should also closely monitor whether high performing plans with high enrollment of individuals with low socioeconomic status witness drop-off or changes in performance on quality measures after adjustment.

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 ongoing audit results, namely involving appeals and grievances, we ask CMS to revisit this proposal.[10]

Plan Finder Civil Money Penalty (CMP) Icon or Other Type of Notice

We strongly support CMS' proposal to display an icon or other notice on the Plan Finder to alert beneficiaries when a sponsoring organization has received a Civil Monetary Penalty (CMP). We

[10] 80 Fed Reg 7919 (February 12, 2015).

appreciate CMS' response to advocates' concerns, and its effort to increase transparency for Medicare beneficiaries.

We recommend that the icon or flag appear with each plan offered by the penalized sponsoring organization along with a link to the letter of enforcement action. As with suspensions of enrollment, plans should also be required to prominently include a link to the notice on their own websites. With respect to "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 election period has ended. Beneficiaries are asked to make market-based enrollment decisions during the annual election period 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.

Further, we ask that CMS issue press releases both for suspension of enrollment actions and civil monetary penalties. It is standard procedure for the HHS Office of Civil Rights to issue press releases when a penalty has been issued or a settlement has been agreed to, even without monetary penalty.[11] Press releases serve the dual purpose of alerting beneficiaries to important information and telling the public more broadly about how well plans are serving Medicare beneficiaries.

Enforcement Actions for Provider Directories

We appreciate that CMS has increased monitoring of MA provider directories. CMS' latest Online Provider Directory Review Report, issued in January 2018, found that more than half of all directories reviewed had at least one inaccuracy, and "[i]naccuracies with the highest likelihood of preventing access to care were found in 45.64 % of all locations."[12] As CMS notes in the report, because MA enrollees "rely on provider directories to locate an in-network provider, these inaccuracies could pose a significant access-to-care barrier."

We strongly support vigorous enforcement of directory accuracy requirements, and urge CMS to proceed with enforcement activities based on ongoing poor results.

[11] See www.hhs.gov/ocr/newsroom/index.html.
[12] CMS Online Provider Directory Review Report, January 2018, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

Innovations in Health Plan Design

Medicare Advantage Value-Based Insurance Design Model Test

Section 50321 of the Bipartisan Budget Act (BBA) of 2018, signed into law after the draft Call Letter was issued, extended the Value-Based Insurance Design (VBID) model nationwide, effective 2020.

We urge CMS to focus on expansion of the VBID demonstration only, and not simultaneously allow benefit flexibility outside of the demonstration. As discussed below under "Medicare Advantage Uniformity Flexibility", allowing such flexibility with neither the results from nor the reasonable parameters and consumer protections in the VBID demonstration will make things more, not less, complex for Medicare beneficiaries.

Section II – Part C

Meaningful Difference (Substantially Duplicative Plan Offerings)

As noted in the draft Call Letter, CMS proposed to eliminate the meaningful difference requirement beginning in CY 2019 as part of the proposed Part C & D rule (CMS-4182-P) published in the Federal Register on November 28, 2017 (82 FR 56336). We appreciate that CMS is still reviewing comments regarding this proposal. As reflected in our comments to this proposed rule, we are strongly opposed to eliminating this requirement that MA plan sponsors "offering more than one plan in a given service area must ensure the plans are substantially different." As noted by CMS in the draft Call Letter, the rationale for this rule is "so that beneficiaries can easily identify the differences between those plans in order to determine which plan provides the highest value at the lowest cost to address their needs."

As we noted in our comments to the proposed rule, there exists a large body of research and analysis that explores the challenges consumers face in making choices about their health insurance coverage, including when there are a multitude of plan options, with little to no standardization.[13] Much of the findings in this work weigh against CMS' proposal to loosen both meaningful difference standards and uniformity requirements, discussed below. Rather than loosening plan requirements, which will result in making informed choices far more difficult for beneficiaries, CMS should instead focus on addressing current methods of beneficiary decision-making, including enhancing consumer-directed tools, also discussed in our comments to the proposed rule.

If, however, CMS should decide to go forward with this proposal, we believe it is very important that there be stakeholder input to the instructions to plans. The details will matter a great deal. We have serious concerns that CMS is planning to fast track this significant change into the 2019

[13] See, e.g., footnote 1 in the Center's Comments on Proposed Rule for Medicare Parts C & D (January 17, 2018): http://www.medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/.

bid cycle without the opportunity for stakeholders to review or comment on its instructions to plans or other details. Absent rescinding this proposal, we urge CMS to slow down.

Health Related Supplemental Benefits

CMS intends to expand the scope of the primarily health related supplemental benefit standard by reinterpreting the statute "to permit MA plans to offer additional benefits as 'supplemental benefits' so long as they are healthcare benefits. Under [CMS'] new interpretation, in order for a service or item to be 'primarily health related,' it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization." According to a CMS press release describing this change, such services can include "coverage of non-skilled in-home supports, portable wheelchair ramps and other assistive devices and modifications when patients need them."[14]

Following issuance of the draft Call Letter, the Bipartisan Budget Act (BBA) of 2018 was signed into law on February 9, 2018. Section 50322 of the Act, entitled "Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees", states that starting in plan year 2020, MA plans can provide supplemental benefits to chronically ill enrollees. Supplemental benefits are defined as benefits that have "a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits." Chronically ill enrollee is defined as someone who "has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of enrollee; has a high risk of hospitalization or other adverse health outcomes; and requires intensive care coordination."

Given that Congress has now addressed the issue of expanding supplemental benefits in MA plans, and has provided an effective date of 2020, we urge CMS to delay implementation of its own proposal to allow more time for drafting of thoughtful guidance, beneficiary education, solicitation of stakeholder feedback, and development of plan oversight protocols. While CMS states that "supplemental benefits do not include items or services solely to induce enrollment" the agency must provide adequate marketing guidelines and oversight to this effect. In addition, CMS must ensure that benefits are actually offered and utilized and that implementation is not directly or indirectly discriminatory.

On the one hand, this expansion of benefits has the potential to improve the lives of MA plan enrollees by providing coverage of services and items they otherwise might not be able to obtain. On the other hand, we note that the rationale of "enhanc[ing] beneficiaries' quality of life and improv[ing] health outcomes" is equally compelling for all Medicare beneficiaries, not just those

[14]CMS Press Release, February 1, 2018, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-02-01.html.

who enroll in Medicare Advantage plans. We urge CMS – and Congress – to promote policies that maintain a level playing field between traditional Medicare and MA to ensure that the full range of covered items and services are equally available to all beneficiaries without regard to how they choose to receive their benefit.

Medicare Advantage (MA) Uniformity Flexibility

CMS has reinterpreted their authority under the Medicare statute and regulations to "permit MA organizations the ability 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 similarly situated enrollees (that is, all enrollees who meet the identified criteria) are treated the same and enjoy the same access to these targeted benefits." CMS reminds MA plans that as they implement this new flexibility, "they must be mindful of ensuring compliance with non-discrimination responsibilities and obligations."

CMS first articulated their reinterpretation of the MA plan uniformity standards in the proposed Part C & D rule (CMS-4182-P) published in the Federal Register on November 28, 2017 (82 FR 56336). The Center submitted extensive comments on this policy change, some of which we reproduce here.[15]

This policy change, which could dramatically increase the range of benefits and cost-sharing between plans, risks allowing some MA plans to devise discriminatory plan designs, intentionally or otherwise. Such flexibility begs the question whether CMS will have the capacity to adequately review plan benefit packages for discriminatory designs. In a climate of reducing regulatory burden for plans, will CMS invest the resources, and have adequate follow through to police discrimination as promised?

As CMS noted in the preamble to the proposed rule, CMS began to test Value-Based Insurance Design (VBID) through the Centers for Medicare and Medicaid Innovation (CMMI) beginning in January 2017. The demo is limited by condition, geography and plan and incorporates significant consumer protections. By loosening uniformity standards for all plans, CMS is putting the proverbial cart before the horse by scaling up an experiment before we have meaningful results, including whether such flexibility – even for a much smaller cohort with specific conditions – improves health outcomes. CMS' policy change is premature in that there is not yet actionable, long-term feedback or lessons from the VBID demo as to whether altering benefits and cost-sharing in this manner is effective among the MA population – a crucial first step before significantly altering plan requirements.

[15] Center for Medicare Advocacy Comments on Proposed Rule for Medicare Parts C & D (January 17, 2018): http://www.medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/.

As noted above, the Bipartisan Budget Act of 2018, signed into law on February 9, 2018 following issuance of the draft Call Letter, expands testing of the VBID demonstration nationally by 2020. Through this provision of the Budget Act, Congress has expressed its intent to introduce flexibility in MA benefits through the parameters of the pre-existing VBID demonstration model, including the built-in consumer protections. Congress did not express an intent to loosen MA restrictions in the manner contemplated by CMS in either the proposed C and D rule or the draft Call Letter.

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. To do so without issuing strong guard rails in the form of consumer protections and more firm restrictions on plans is a stark departure from the more thoughtful and cautious approach recently taken by CMS in rolling out the VBID demo.

When CMMI first proposed a VBID demo, the Center and other consumer advocates provided extensive feedback.[16] The resulting demonstration model reflects CMS' careful consideration of many important beneficiary protections. Such protections, or guard rails, included strong and clear parameters for program design, including: a multi-stakeholder and transparent process for identifying high-value services and developing conditions of participation; permitting only cost-sharing reductions; limiting or prohibiting advertising and other pre-enrollment marketing of cost sharing adjustments; and opt-in beneficiary selection. Here, CMS allows alteration of benefits and cost-sharing without regard to the extensive consumer protections included in the limited VBID demo.

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 do not mislead prospective enrollees with promises of specially-

[16] See CMA Comments re: Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model September 17, 2015 available at: http://www.medicareadvocacy.org/cma-comments-re-medicare-advantage-ma-value-based-insurance-design-vbid-model/.

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" that will be available following issuance of the Final Call Letter for plans that have questions about whether a proposed targeted supplemental benefit is allowable. This amounts to an abdication of regulatory oversight.

The Center is opposed to this proposal. Should CMS choose to proceed though, it must, at a minimum, include basic consumer protections and oversight included in the VBID demo.[17] We note that none of these protections or oversight requirements are addressed, contemplated or hinted at in either the proposed rule or the draft Call Letter.

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.[18] 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

[17] See discussion of consumer protections in the Center's Comments on Proposed Rule for Medicare Parts C & D (January 17, 2018): http://www.medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/.
[18] *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.

circumstances of the beneficiary. For example, notices sent to those who are already enrolled in the Low Income Subsidy program should not say "you may qualify for Extra Help."

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

Parts 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.

The situation is improving but challenges persist. Thus, we believe that CMS' 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 to identify plans and plan sponsors that have repeated complaints in order to focus education and enforcement.

Section III–Part D

Part D Opioid Overutilization Policy

We appreciate the important goals in this policy. We ask, however, that CMS extend its exceptions to include beneficiaries who are at end of life but not enrolled in hospice and those in palliative care. The hospice and cancer exclusions are inadequate to address the urgent and appropriate needs of other beneficiaries in similar circumstances.

LIS Enrollee Cost-sharing for Out-of-Network Part D Drugs

We thank CMS for using the Call Letter to remind plans that LIS enrollees must be reimbursed the entire amount of an approved out-of-network claim minus their applicable LIS cost-sharing amount and to remind plans further of the importance of timely reimbursements of those claims. Advocates working with beneficiaries have reported that issues around this policy have arisen primarily when beneficiaries have received needed Part D medications from an out-of-network hospital pharmacy during an outpatient procedure, or when they had an emergency room visit or were in a hospital in observation status. The reminder and clarification in the Call Letter are most helpful. We also ask that, during the next updates to the Prescription Drug Manual, CMS provide cross-references to further clarify its policy. Specifically, we suggest that, at Chapter 5 at 60.1, CMS add a statement along the following lines: "Reminder: For LIS beneficiaries, the plan sponsor must compare the amount due from a non-LIS beneficiary under this section to the

maximum cost-sharing and deductible amounts due from a low-income subsidy eligible beneficiary and charge the LIS beneficiary the lesser of the two amounts. See Chapter 13 at 60.4.4. ” We also proposed that at Chapter 13 at 60.4.4, CMS add a note stating: “The requirement that the beneficiary be charged the lesser of the two amounts applies in all cases, including the calculation of reimbursements for out-of-network pharmacy payments as discussed in Chapter 5 at 60.1.” We also ask that CMS consider providing scripts and training to 1-800-MEDICARE staff on the issue.

Timely Updates to LIS Status Based on Best Available Evidence

We appreciate the admonition to plans to ensure that the Best Available Evidence (BAE) policy is implemented correctly and quickly. We continue to hear of cases where beneficiaries or their advocates have trouble finding plan staff who are familiar with BAE. At least some plans appear not to have particular staff designated to handle BAE issues, or they have not sufficiently educated other staff to spot and refer these issues. We recommend that CMS encourage all plans to designate such individuals and ensure that their call centers have that information available. There continue to be problems in getting quick resolution once BAE information has been submitted. An additional longstanding concern is ensuring that pharmacy staff are aware of the BAE process. Pharmacy staff turnover is a significant challenge in maintaining the needed knowledge at the point-of-sale. We ask that CMS also reiterate to plan sponsors their obligation to be part of ongoing education of their in-network pharmacies on BAE.

Section IV–Medicare-Medicaid Plans

As Medicare-Medicaid Plans (MMPs) become increasingly available to older adults and people with disabilities, clarity of communication and sufficient oversight are increasingly important. We continue to appreciate CMS’s targeted attention to these plans and the unique needs of their enrollees.

Network Adequacy Determinations: CMS will require MMPs to submit their network information regularly to ensure that each MMP continues to maintain a network of providers that is sufficient in number, variety, and geographic distribution to meet the needs of the enrollees in its service area. We continue to strongly support this requirement, and we urge CMS to enforce existing regulations that require MMPs to update their provider directories, as we have worked with MMP enrollees who have received dated network information, resulting in delayed access to care. We also encourage CMS to consider, when reviewing the network information, whether the listed providers who speak additional languages can accommodate persons with disabilities and are currently accepting new MMP patients.

Formulary and Supplemental Drug Files: CMS requires MMPs to submit Part D formulary and other information in a supplemental file about non-Medicare covered drugs that are covered

under Medicaid program rules. While we understand the historical reason for this separation, we urge CMS to work towards the creation of integrated formulary submissions and concurrent, rather than separate, review of the Part D and Medicaid-covered drugs.

We encourage CMS to develop special procedures for prescription drugs that may be covered under Part D in some circumstances but, when they are not, are covered under the Medicaid program. CMS should ensure that there is adequate coverage and coordination between the formulary and supplemental drug file for these prescriptions. We find that these medications can cause particular access problems. Examples include prescriptions drugs for cough and cold symptoms, medicines that are frequently used for a medically accepted but not FDA-approved indication, and prescription drugs to affect weight gain.

Issues Unaddressed in Draft 2019 Call Letter

In addition to the issues discussed above, the Center raises the following topics that are not addressed in the draft Call Letter, about which we provide comment, below.

MA Network Adequacy

In 2015 the General Accounting Office (GAO) released a report entitled "Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy". GAO examined several factors relating to CMS' oversight of MA organization (MAO) network adequacy, and made corresponding findings, including: how CMS defines network adequacy and how its criteria compares with other programs; how and when CMS applies its network adequacy criteria; the extent to which CMS conducts ongoing monitoring of MA organization networks; and how CMS ensures that MA organizations inform beneficiaries about terminations.

While CMS has made efforts to address some of the deficiencies highlighted by GAO, so far such efforts appear to be primarily directed at provider directories alone. CMS noted in the draft 2016 Call Letter that "[t]he data collected through our monitoring activities could drive additional reviews of network adequacy, as well as future monitoring and/or audit-based activities" [emphasis added]. We urge CMS to more broadly expand its oversight and definition of network adequacy, as suggested by GAO.

Provider Network Terminations

We remain disappointed that CMS has taken no further action, either in Call Letters or in rulemaking, to strengthen consumer protections surrounding MA plan mid-year provider network terminations. The most effective way to protect consumers from being trapped in their plans after their own doctors are involuntarily terminated is to prohibit MA plans from terminating network providers mid-year without cause. Not only did CMS retreat from this option in the final 2015 Call Letter, but there has been no attempt to extend the current 30-day advance notice to affected beneficiaries, as also suggested in the 2015's Draft Call Letter.

Further, CMS has failed to strengthen or otherwise expand the limited special enrollment period (SEP) right available only to beneficiaries affected by "significant" network terminations. In addition, the availability of this limited SEP right is not adequately expressed in beneficiary-oriented materials, including those issued by plan sponsors (e.g. the Annual Notice of Change) or by CMS (e.g. Medicare & You and the www.medicare.gov website). More accurate provider directories, while a welcome improvement in consumer information, is not a solution to this problem.

Conclusion

We appreciate the opportunity to submit these comments. For additional information, please contact David Lipschutz, Senior Policy Attorney, dlipschutz@medicareadvocacy.org, and Kata Kertesz, Policy Attorney (admitted in Maryland only; working under the supervision of Toby S. Edelman, a member of the D.C. Bar; practice limited to federal Medicare law) kkertesz@medicareadvocacy.org, both at 202-293-5760.

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