Comments from Fallon Health (H9001) on 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

**A. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability**

***1. Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions***

Fallon Health feels that limiting the program to only opioids will limit a health plan’s ability to target and intervene on other potentially misused controlled substances. We recommend CMS not limit this provision to opioid drugs.

Fallon Health supports not requiring prescriber agreement to implement pharmacy lock as the beneficiary that is most likely to get a pharmacy lock is seeing multiple prescribers.

Fallon Health supports not requiring a 6-month waiting period before initiating a prescriber lock.  This is 6 months of opioid fills that may not be medically necessary.  The longer the unnecessary mediations are continued, the more difficult it may be for health plans to reduce opioids and coordinate care.  We feel that coordinating a member’s opioid therapy is best handled by the prescriber.  Locking the member to a prescriber (or a select few prescribers) re-enforces this relationship and prevents unnecessary opioids from being filled at all.

The proposed rule would, for an individual identified as an at-risk beneficiary, restrict the beneficiary’s dual SEP until the date the beneficiary’s at-risk status is terminated based on a subsequent determination, including a successful appeal, or at the end of a 12-month period calculated from the effective date the sponsor provided the beneficiary in the second notice whichever is sooner. Will a beneficiary identified as “at-risk” still be allowed to make enrollment and disenrollment decisions based upon the Annual Election Period (AEP) or will the SEP restrict all enrollment decisions for a 12-month period? We recommend that CMS provide more detail on this SEP restriction.

Finally, we recommend that CMS provide detail on how an organization will know that a beneficiary has been identified as “at-risk” and has had a SEP restriction placed upon them. Will CMS issue a report to plans or will this information be displayed in MARx?

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***7. Coordination of Enrollment and Disenrollment Through MA Organizations and Effective Dates of Coverage and Change of Coverage - Default Enrollment***

Fallon Health respectfully request clarification of the applicability of the definition of “affiliated Medicaid managed care plan” in 42 CFR 422.66 to Medicaid Accountable Care Organizations (ACOs) in Massachusetts. ACOs differ from traditional Medicaid managed care plans in a number of ways, most notably that most ACOs are essentially partnerships between an insurer and a provider organization. Would an ACO that is a partnership between an insurer and a provider organization be considered an “affiliated managed care plan” in relation to a Medicare Advantage plan offered by the same insurer? We believe that it should be consider as such, but request that CMS provide clarification on this point.

A. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability

***8. Passive Enrollment Flexibilities To Protect Continuity of Integrated Care for Dually Eligible Beneficiaries***

We recommend that CMS provide more clarification around which entity would be managing or overseeing the passive enrollment process: CMS, the state Medicaid agencies, or a combination of both working together? We also request more guidance for the process of passively enrollment eligible beneficiaries. Would all remaining eligible D-SNPs within the state be given an equal share of the eligible beneficiaries or would they be enrolled via some other process? We are generally in favor of this proposal so long as the passive enrollment process is explained in more detail and the criterion for distributing those eligible beneficiaries is fair and equitable for all eligible D-SNPs. We respectfully request that CMS provide more detail on how the passive enrollment process will be overseen and how eligible enrollees will be distributed among the participating D-SNPs in the state.

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***10. Establishing Limitations for the Part D Special Enrollment Period for Dual Eligible Beneficiaries***

This proposal would results in enrollees not being allowed to make changes outside of the two scenarios noted within the proposed rule [within a certain period of time after a CMS or State-initiated enrollment; or as a onetime annual opportunity that can be used at any time of the year]. Our organization is concerned about the impact this would have on our D-SNP and Massachusetts’ Senior Care Options (SCO) programs. If FIDE plans contract with the state Medicaid agency requires voluntary enrollment and disenrollment throughout the year this proposed rule will have significant impact. On page 56375 of the federal register, CMS presents two alternatives that were considered. The second of these alternatives would prohibit beneficiaries from using the SEP to elect a non-integrated MA-PD plan, but would allow continuous use of the dual SEP to allow eligible beneficiaries to enroll into FIDE SNPs or comparably integrated products for dually eligible beneficiaries. Our organization recommends that, as in this second alternative, the SEP still allow continuous enrollment into the D-SNPs and SCO plans.

If the existing SEP is changed from an open-ended monthly SEP to one that may be used only in the following circumstances (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, we request that CMS clarify how health plans are to determine if a member or enrollee has already made their one annual SEP election.

**A. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability**

**11. Medicare Advantage and Part D Prescription Drug Plan Quality Rating System - Ensure Additional Transparency for Star Ratings**

Fallon Health supports transparency in the Star rating cut points prior to the calendar year on which the ratings are based.  This allows for appropriate goal setting and allocating appropriate financial resources.

**A. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability**

***12. Any Willing Pharmacy Standard Terms and Conditions and Better Define Pharmacy Types***

If CMS issues a final rule that is interpreted to mean that plans should allow any pharmacy to join preferred networks, then some Medicare Advantage plans may need to open preferred cost-sharing networks to additional pharmacies to join in order to comply with the “Any Willing Provider” requirements. This would certainly diminish the benefits and cost savings associated with a health plan establishing preferred networks and has the potential to increase costs across the entire Part D Program. Fallon Health opposes any changes to the Any Willing Provider requirement that would have the effect of eliminating the concept of preferred pharmacies. Fallon Health recommends that CMS maintain the current rules which allow preferred pharmacies, since this will result in significant cost savings to beneficiaries and the Medicare Program.

**A. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability**

***17. Application of Manufacturer Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale***

Requiring manufacturer rebates to be passed through at POS would increase member drug price volatility, increase taxpayer costs, increase government spending (and thus taxpayer costs) and provide a financial windfall for manufacturers (based on CMS’s own financial impact estimates). In addition, this would provide manufacturers with insights into rebates across Plans and encourages manufacturers to reduce rebates. It also greatly increases administrative costs. Such a policy would increase beneficiary premiums (since currently rebate monies are used to lower premiums across the board for all beneficiaries), which could result in fewer people signing up for Part D and thus reduce Medicare beneficiary access to medications.

The application of Pharmacy Price Concessions would severely impede pay-for-performance programs. Congress and CMS have taken steps toward a more value-based health care payment system through the adoption of pay-for-performance methodologies in traditional Medicare and the Medicare Advantage program. Similar to other providers, incentivizing pharmacies to improve performance and lower costs increases value for Medicare beneficiaries.

Under performance-based pharmacy arrangements negotiated by our PBM and pharmacies, pharmacies can receive positive or negative payment adjustments based upon criteria such as:

* + Formulary compliance;
  + Helping beneficiaries remain adherent to their prescribed regimens, including statin and diabetes drugs;
  + Reducing inappropriate drug use and/or overutilization;
  + Engaging beneficiaries to participate in, and reporting metrics related to, management programs; and
  + Actively engaging in customer satisfaction and service programs.

These performance criteria are generally based upon areas CMS has identified as indicating quality services in Part D, and most of these are used by CMS through its Star Ratings system to evaluate Medicare Advantage and Part D plans. We recommend that CMS not eliminate pharmacy payments accounted for under DIR in Medicare Part D as this would severely constrain the ability to create these types of pay-for-performance programs in the pharmacy space.

**B. Improving the CMS Customer Experience**

**1. Restoration of the Medicare Advantage Open Enrollment Period**

The 21st Century Cures Act eliminates the existing MA disenrollment period (MADP) that currently takes place from January 1st through February 14th of every year and, effective for 2019, replaces it with a new Medicare Advantage open enrollment period (OEP) that will take place from January 1st through March 31st annually. The new OEP allows individuals enrolled in an MA plan to make a one-time election to go to another MA plan or Original Medicare.

Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage.

Medicare Advantage plans that have achieved a 5-Star plan rating are allowed to market to beneficiaries all year round. The 21st Century Cures Act would add the new OEP period as a statutory requirement. Will CMS be allowing an exception to the statutory requirements of the The 21st Century Cures Act and allowing 5-Star plans year round marketing?

**B. Improving the CMS Customer Experience**

**4. Revisions to Timing and Method of Disclosure Requirements - Allowing Electronic Delivery of Certain Beneficiary Documents**

Fallon Health supports this proposal.

**B. Improving the CMS Customer Experience**

**13. Reducing Provider Burden— Comment Solicitation**

Health plans have the right to request medical records for FWA as patient-related information from a physician or medical facility may be necessary to conduct our review and to determine if there is fraudulent activity.  The process for requesting medical records varies slightly by provider type, as some plans may have access to a provider’s medical records system.   There are times when a health plan requests records from a provider’s office only to find that the provider has an overlapping record request from another department within the same health plan or other health plans altogether. With the increase in FWA referrals, it’s difficult to get around the need to request provider records or do an on-site audit for evidence.

We recommend that CMS provide a template letter to health plans explaining why the Health Plan is asking for the medical records that the plan could then share with the provider. A letter stating something to the fact this is to improve the care and cost of their patient who receives Medicare Advantages benefits. One the biggest burdens we hear from providers is from small offices that do not have the manpower to assist with the request and/or the providers’ offices have multiple requests from different Health Plans requesting records at the same time.