JUSTICE IN AGING
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March 3, 2017

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Centers for Medicare and Medicaid Services
Baltimore, MD

Sent electronically via email to: AdvanceNotice2018@cms.hhs.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter

Justice in Aging appreciates the opportunity to comment on the CY 2018 Advance Notice of Methodological Changes and the CY 2018 Call Letter for Part C and Part D Plans.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

Methodological changes and payment policies

1. Section A. MA Benchmark, Quality Bonus Payments and Rebate

We support the proposed payment rates that will result in Medicare Advantage (MA) plans being paid based on the fee-for-service rate. This approach is consistent with applicable law and the longstanding goal since the start of the Medicare Advantage program to bring MA plan payments in line with costs under Original Medicare. We support these policies, which will contribute substantially to stabilizing the finances of the Medicare program.

2. Section H. Medicare Advantage Coding Pattern Adjustment

We support CMS efforts to prevent inappropriate upcoding. We believe that a highly effective way to address upcoding is to look at the correlation between coding intensity and service intensity. We have seen in some dual eligible demonstrations that plans, after a careful health risk assessment, have identified previously undiagnosed and untreated serious conditions. If such identification is followed up with a comprehensive treatment plan to address the newly-identified conditions, then the goals of care

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coordination have been addressed. If, instead, there are patterns of increases in coding intensity without corresponding response in the provision of services, that pattern is a clear indicator of concern.

Call Letter Section I

1. Annual Calendar

We continue to urge CMS to consider a calendar that requires separate mailings of the ANOC and EOC for MA plans and for Part D plans. Further, although we appreciate the efforts that CMS has made over the past several years to improve and simplify the language of both documents, we believe there continues to be substantial room for further improvement. We ask particularly for an ANOC more tailored to the individual that specifically highlights the provider changes and formulary changes that affect the providers and prescription drugs used by the beneficiary. We also ask that the ANOC be tailored to the individual's LIS and Medicaid status. Justice in Aging would be happy to work with CMS and other stakeholders in this effort.

2. Adjusting Star Ratings for Audits and Enforcement Actions

We are pleased that CMS has been examining closely the disconnections that have appeared between star ratings and audit findings. These continue to be a concern, particularly where a plan has been under enrollment sanction. Suspension of enrollment is only instituted when CMS determines that a plan's conduct poses a serious threat to the health and safety of Medicare beneficiaries. We believe, therefore, that an automatic reduction of at least one star is fully appropriate for plans with intermediate sanctions. An across the board one-star reduction levels the playing field so that previously highly rated plans are not disproportionately disadvantaged. It also, importantly, signals the severity of the violations and offers beneficiaries a tool that helps them to realistically compare plans. When violations are so severe that they trigger enrollment sanctions, it is not enough to merely include them as part of a measure or sub-measure. That lower level of attention does not send the right signal to plans or to beneficiaries. When CMS finds that a plan's systems pose a serious threat to the health and safety of Medicare beneficiaries, that finding must have an impact on overall ratings. If such a serious finding does not have a significant impact on the overall star rating for a plan, the disconnect between audits and star ratings is too great and diminishes the credibility of both processes.

We also urge CMS to consider additional measures to increase transparency around both Civil Monetary Penalties and enrollment sanctions. We appreciate that information about both is available on the CMS website. We also thank CMS for adding links to enrollment sanctions on the plan finder and the plan website during the period in which a plan is under an enrollment sanction. Once a sanction is lifted, however, it becomes difficult for a beneficiary or anyone not well acquainted with the intricacies of the CMS website to review the compliance history of a plan. We suggest a compliance history link as part of a plan's listing on the plan finder. To be fair to all plan sponsors, we suggest a lookback period, perhaps three or five years, that would encompass a full audit cycle. We further suggest that plans be required to have a reasonably prominent link to compliance history on their websites as well. Having these links available empowers consumers to make more fully informed choices. Further, because compliance actions are a factor in star-based payments, the links would contribute to transparency about MA financing.

3. Innovations in Health Plan Design

We appreciate the updates on the Medicare Advantage Value-Based Insurance Design (V-BID) Model and the Part D Enhanced MTM Model underway through the Center for Medicare and Medicaid Innovation (CMMI). We particularly appreciate the commitment of CMS to develop an Alternative Payment Models (APM) Beneficiary Ombudsman to monitor the beneficiary experience in new and emerging CMMI models.[1] As has been shown in the dual eligible demonstration projects, an ombudsman program is an effective vehicle to monitor enrollee experiences to ensure that both problems and best practices are captured in a systemic way.

Call Letter Section II, Part C

1. Plans with Low Enrollment

CMS proposes allowing Special Needs Plans (SNPs) with low enrollment in areas with insufficient competition to remain operational. We support this proposal. The experience of PACE programs, financial alignment demonstrations and other programs that address care coordination for high needs populations demonstrate that the kind of scaling common for plans with significant membership of "community well" populations may not be appropriate or needed when serving specialized groups. We urge CMS to continue careful monitoring of the viability of all MA plans as well as their capacity to offer needed services but we agree with CMS that, for SNPs, rigorous cutoffs may not always be good indicators of whether the needs of beneficiaries are being met.

2. Optional Supplemental Benefits

We support CMS' continued evaluation of supplemental benefits packages to ensure that such packages are non-discriminatory and provide value to MA enrollees. Going further, we encourage CMS to review the range and type of supplemental benefits currently offered by MA plans nationwide and to make any such analysis publicly available.

As advocates for low income beneficiaries, one concern we have is the overlap that can occur between supplemental benefits and the benefits that dual eligibles can receive through Medicaid. The overlap creates potential for improper marketing of MA plans to dual eligible.

Leaving marketing issues aside, we also have seen that the intersection of supplemental benefits with Medicaid benefits can create a thicket that is difficult for dual eligibles to navigate. For example, supplemental dental benefits may cover some procedures that are different from dental coverage under

[1] *See* CMS "Advancing Care Coordination through Episode Payment Models (Cardiac and Orthopedic Bundled Payment Models) Final Rule (CMS-5519-F) and Medicare ACO Track 1+ Model," (Dec. 2016), available at: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

Medicaid, but also may overlap for some other specific dental procedures. While the supplemental benefit may in fact be very helpful for a dual eligible plan member, it is important for plans to be knowledgeable about the intersection with Medicaid benefits and be able to assist members in understanding how to best use both benefits. As CMS reviews plan supplemental packages, we ask that the agency also consider how to use that review data to address these issues. We would be happy to work with CMS and other stakeholders to explore these issues further.

Call Letter Section III, Part D

1. Part D Tiering Exceptions

We are very appreciative that CMS is planning to use the Call Letter to address ongoing challenges with meaningful application of the tiering exception. We strongly support the clarifications and instructions in the Call Letter, including particularly the requirement for data collection around appeals. We add the following proposals.

a. Working with providers

The draft Call Letter reminds plan sponsors that their obligation to make reasonable and diligent efforts to obtain supporting information from providers fully applies to tiering exception requests. We urge CMS to provide more specific guidance, telling sponsors that they should identify for the provider all those drugs that the plan considers to be alternatives so that the provider can more easily address their appropriateness as substitutes.

Further, because the availability of tiering exceptions is not widely known among providers, we ask that CMS encourage MA plan sponsors to educate their in-network providers about the exception and how to support an exception request.

We also ask that CMS ensure that plans sufficiently educate their in-network pharmacies about the exception and direct their pharmacies to provider information about the exception to individuals who express concern about high co-pays on non-preferred tiers.

b. Educating Consumers

Because tiering exceptions are not well understood by consumers, we urge CMS to require plan sponsors, as part of their overall obligation to explain benefits to members, to undertake specific steps to educate members about their rights to request a tiering exception. We believe such steps should include scripts at plan call centers for when individuals express concerns about non-preferred tier pricing and informational sheets for in-network pharmacies to distribute to beneficiaries with concerns about pricing for their non-preferred prescription. Remedial education is needed. We ask that CMS conduct secret shopper surveys to determine the extent to which plans proactively provide accurate and helpful information about tiering exceptions to their members.

2. Decreasing Health Disparities

We appreciate that CMS is reinforcing the importance of addressing health disparities in concrete ways. With respect to limited English proficient (LEP) plan members, we ask that CMS consider requiring plans to track and report data on frequency of use of interpreters and correlate that information to the encounter data of individuals that self-identify as LEP. This information would provide an important data point to help identify patterns of underservice to specific vulnerable groups.

Policies that were not addressed in the draft Call Letter

1. Part D transition supplies when an exception expires

We ask CMS to use the Call Letter to address prescription drug protections for individuals who lose prescription drug access because an exception is expiring. Currently Section 30.4 of Chapter 6 of the Prescription Drug Benefit Manual provides that individuals with an expiring exception have the right to a one-time transition fill. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf CMS, however, overrode that directive with an August 19, 2016 memorandum distributed through HPMS that "clarified" that CMS does "not expect Part D sponsors to include expiring formulary exceptions in their transition policies." The reason for the reversal was plan readiness, specifically that "plans will need to make significant system changes to implement this policy, particularly with respect to exceptions expiring mid-year."

We recognize the need to allow plan sponsors time to make systems change. We strongly urge CMS, however, to set a firm start date for this transition requirement and use the Call Letter to advise plans that the requirement will become operative at the beginning of the 2018 plan year.

The requirement to apply transition rules to expiring exceptions is an important consumer protection and we had appreciated its clear inclusion in the January 2016 PDBM updates. Plan members, in order to have received an exception in the first place, have already shown the medical necessity of the drugs at issue. Given the already established importance of the drug to their health, it is critical that plan members have access to a transition supply while they pursue a fresh exception or move to a different medication. If CMS gives plan sponsors notice in the Call Letter, that should give them adequate time to make needed systems changes in time for the start of the 2018 plan year.

2. Inappropriate Billing of QMBs

In the 2017 Call Letter, CMS reminded plan sponsors of their obligation to prevent inappropriate billing by plan providers of members that are dual eligibles or QMBs. We believe the inclusion on the Call Letter significantly raised the visibility of QMB billing protections within plans and with plan providers, and we thank CMS for that and for the many other steps the agency has taken to reduce inappropriate billing, particularly through the work of the Medicare-Medicaid Coordination Office. We have continuing concerns, however, about whether plans have put systems in place so that providers can

verify dual or QMB status of patients, either through electronic systems or through identification on plan member cards. Our sense is that challenges remain in these areas and we ask CMS to request specific information from plans to determine the extent of remaining problems.

Thank you again for the opportunity to comment. If you need additional information, please do not hesitate to contact me at JGoldberg@justiceinaging.org.

Sincerely,

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