NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

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**VIA ELECTRONIC SUBMISSION**
AdvanceNotice2015@cms.hhs.gov

Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: Advance Notice of Methodological Changes for Calendar Year 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter**

The National Senior Citizens Law Center (NSCLC) is pleased to submit these comments on the Advance Notice of Methodological Changes for 2015 and accompanying draft call letter.

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults, especially women, people of color and other disadvantaged minorities. Ensuring access to Medicare programs and improvements in delivery of Medicare services, particularly to low income seniors, have been priority issues for our organization for decades.

Our comments are as follows:

Attachments I & II: Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-For Service Growth Percentage for CY 2015 and Changes to Part C Payment Methodology

We continue to support policies enacted through the ACA that will gradually align MA reimbursements with Traditional Medicare. These policies are critical to stabilizing the fiscal health of the Medicare program, and to ensuring efficient spending of taxpayer dollars. CMS' proposed payment rates are reflective of these policies, and we support their implementation as such.

The law also requires that MA payment rates be revisited on an annual basis to account for estimated per beneficiary spending by Traditional Medicare. The cost to provide the same benefits under the fee-for-service program is the legally required and appropriate starting point for calculating MA payment rates. Both Medicare cost growth and national health expenditures have grown at historically small rates over the last several years. It is appropriate that this slower growth is reflected in the MA payment

methodology. These slowed rates translate into an improved financial outlook for the Medicare program as well as lower costs and stable premiums for beneficiaries. The 2015 MA payment rates proposed by CMS appropriately reflect this slower growth, and we do not believe that MA plans should be insulated from these encouraging trends.

Additionally, we support the phase out of the three-year demonstration project that awarded Quality Bonus Payments (QBP) to for plans which scored only an average score (3 stars) in important quality metrics. Rewarding only high performing 4 and 5 star plans with QBP percentage increases appropriately incentivizes plans to provide excellent service to beneficiaries.

Attachment VI: 2015 Call Letter

**Contracting Organizations with Ratings of Less Than Three Stars in Three Consecutive Years – Effective Date of Termination Authority (p. 74)**

We support CMS in the use of its authority to terminate contracts of consistently low-performing plans in 2015. We appreciate CMS's advice to organizations to assess their risk of termination and to consider non-renewal rather than termination.

**Section II – Part C**
**F. Part C Cost-Sharing Standards (p. 105)**

While we appreciate that CMS is reducing skilled nursing facility (SNF) cost-sharing requirements for the first 20 days from $50 to $40 per day for voluntary MOOP plans and from $25 to $0 per day for mandatory MOOP plans, we remain concerned that MA plans are allowed to charge any cost-sharing for the first 20 days in a SNF. As noted in comments to previous Call Letters, we continue to believe that CMS is misinterpreting section 3202 of the Affordable Care Act that limits cost-sharing to the level required in Traditional Medicare for SNF care. MA plans should not be permitted to allow cost-sharing for the first 20 days of a SNF stay, as long as the overall cost-sharing is actuarially equivalent to the cost imposed under Traditional Medicare for the complete SNF benefit. The average stay in a SNF is well under the 100 day benefit. The current CMS policy allowing MA plans to front-load their SNF cost-sharing requirements to the first 20 days undermines the protection that these provisions were designed to establish. We ask CMS to require MA plans to apply Traditional Medicare's $0 cost-sharing for the first 20 days of skilled nursing care.

Likewise, home health services should not be subject to any cost sharing even for voluntary MOOP plans.

***Part C Policy Updates***
**A. Increasing Transparency for Beneficiary Part C Cost Sharing for Inpatient Stays (p. 108)**

We share CMS's concern about transparency regarding MA plans that do not use the traditional Medicare benefit periods as the basis for charging cost-sharing for inpatient services. We do not

believe that such transparency is enough, however. Rather, the cost sharing outlined in the CMS example, with two in-patient deductibles and two sets of per diem cost sharing for an individual who starts at an acute care hospital and is transferred to an inpatient rehabilitation hospital, needs to be prohibited outright.

Regulatory changes are needed to provide stronger beneficiary protections from excessively high inpatient cost sharing structures, including placing limits on MA plan inpatient cost-sharing. Unless and until that happens, at a minimum, we support CMS's interim proposal to revise the templates for Evidence of Coverage (EOC), Annual Notice of Change (ANOC) and Medicare Plan Finder (MPF) to more clearly show each plan's inpatient cost sharing structure.

**I. Exceptions to Policies Permitting Plans to Limit Durable Medical Equipment (DME) to Certain Brands and Manufacturers (p.112)**

We support the continued exception of certain DME from the general rule allowing plans to limit access based on brand or manufacturer. We urge CMS to clarify, however, that the exceptions and appeals process is available for those beneficiaries who require a particular brand of DME due to their unique clinical situation.

**J. Innovations in Health Plan Design (p. 113)**

We appreciate that CMS is soliciting comment on testing value-based insurance arrangements and other beneficiary engagement initiatives through the CMS Innovation Center. While we believe that value-based insurance design holds promise, we urge CMS to approach these models with caution. In particular, we have strong reservations about value-based insurance models that increase beneficiary cost sharing to discourage patients from seeking low-value health care services. We believe that CMS should prohibit this practice from any demonstrations, and should instead only test models that lower beneficiary cost sharing to encourage the use of high-value health care services. The potential harms of increased cost sharing, particularly for low-income populations, are well documented.[1]

In addition, according to a 2006 RAND study, added cost sharing has little utility in controlling service use once a patient enters the health care system.[2] This finding confirms what we know to be true through our experience serving people with Medicare: health care providers—not beneficiaries—order services and ultimately drive utilization trends. In other words, Medicare beneficiaries are not positioned to evaluate high-value versus low-value services. Cost sharing incentives demand a high level of sophistication and knowledge on the part of beneficiaries to evaluate care options that are ultimately recommended by their doctors. Given this, we do not

[1] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" (as of June 2011) available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See literature under: "Cost-sharing Research and Literature"; Swartz, K. "Cost-Sharing: Effects on Spending and Outcomes" (Robert Wood Johnson Foundation: December 2010), available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

[2] RAND, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate" (January 2006), available at: http://www.rand.org/pubs/research_briefs/RB9174.html.

believe that value-based insurance models should be pursued in the absence of complementary efforts to better inform and educate consumers.

**Part C Provider Contract Termination Guidance (p. 115** )

We support CMS's proposal to provide needed protections for consumers to mitigate the disruption in services that can occur as a result of unilateral cuts to networks.

*CMS Guidance Related to MAO Network Changes.* In response to CMS' solicitation of comments, we support a uniform standard or threshold that constitutes a "significant" change that should be applied globally to MA plans. We believe that CMS should consider a combination of factors when determining whether a network change is "significant," including a percentage of physician types leaving a given network as well as a percentage impact threshold overall. In addition, we suggest that notable changes, specifically the elimination of a hospital or other multi-provider practice, should automatically meet the bar for a "significant change" under the uniform standard.

*Notifying CMS of Significant Terminations.* We support CMS' proposal "to institute a new procedural rule to facilitate CMS oversight of MAO compliance with access requirements when a significant change to a provider network is contemplated." We agree that MAOs should be required to notify their respective CMS Regional Office Account Managers (AM) no less than 90 days prior to the effective date of the planned termination(s).

Rather than submission to CMS upon request, however, MAOs should be required to submit written plans providing detailed descriptions of the steps the MAO will take to ensure that affected enrollees are able to locate new providers that meet their individual needs. We also urge that MAOs be required to submit information about the number and dispensation of continuity of care requests that they receive so that CMS may confirm that the MAO is in compliance with all applicable requirements.

*Notification to Enrollees Affected by Provider Contract Terminations.*

Changes to Networks During the Plan Year. We strongly support CMS's focus on improving notice to plan enrollees about provider contract terminations. Rather than a "best practice," though, we urge CMS to require the following of plans making significant network changes :

- Provide at least 60 days advance notice with a follow up at 30 days.
- Include CMS's proposed information concerning contact information of in-network providers that enrollees can access for continued care, information regarding how enrollees can request continuation of ongoing medical treatment or therapies with their current providers, and customer service number(s) where answers to questions about the network changes will be available in notices to enrollees along with the identification of the provider(s) being terminated from the network.

We support including individually-tailored information, as described below relating to ANOCs, as a best-practice to be encouraged and further explored.

Further, CMS should require through rulemaking that enrollees be notified prior to the start of the Annual Coordinated Election Period (AEP) of any provider contract terminations that have already been initiated by the organization and will be effective on or after January 1 of the following year. Any changes accomplished through such rulemaking should be effective for the AEP for 2015, which begins on October 15, 2014.

Notices in Annual Notice of Change (ANOC) and Evidence of Coverage (EOC). We support CMS's proposal to strengthen current requirements regarding plan's responsibilities to notify enrollees of network changes in their Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) materials. We endorse the proposed required language concerning enrollees' rights in the event that a plan changes its provider network during the year. However, we believe that CMS should also require plans to provide more specific, individually-tailored information about physician network changes in the ANOC. This requirement would ensure that beneficiaries have the relevant information they need in a timelier manner and in an appropriate forum.

We recommend this information be conveyed as simply as possible so that beneficiaries are able to utilize the information. This should be achieved by providing individually-tailored enrollee notices informing each enrollee that providers they are seeing or have seen will no longer be part of the MA plan's network. Such notice should follow the format of "for the xxxx plan year, Dr. X (specialist in x), who treated you on [Date], will no longer be a part of this MA plan and any services provided by him/her will not be covered through this MA plan." The notice should highlight the providers that an individual enrollee has visited, as well as include a comprehensive list of all primary care providers, all specialists, and healthcare facilities in the MA plan's geographic area that will no longer be in network the following plan year.

Contracted Provider Notification and Right of Appeal. We support CMS's proposal to afford providers more than a 60 day notice of a contract termination, consistent with longer notification periods for plan enrollees. As noted by CMS, a longer period would give providers sufficient time to exercise their appeal rights and for the appeals process to conclude, ideally before affected enrollees are notified of the change.

**Section III – Part D**
**Access to Preferred Cost Sharing (p.123)**

We share in CMS's concerns, articulated in the call letter and in the proposed CY2015 Part C&D rule,[3] that preferred cost sharing networks are not currently serving beneficiaries or the Medicare Program effectively.

[3] 79 Fed. Reg. 1918 (Jan. 10, 2014).

Advocates have heard from beneficiaries for whom the 'preferred' pharmacy for a particular plan is inaccessible, inconvenient or otherwise not the pharmacy that the beneficiary would prefer to use. CMS's finding that some preferred pharmacy networks are so limited that beneficiaries find it very difficult to access the cost sharing they reasonably expected is worrisome, and we fully support CMS's continued study of this issue.

We urge CMS to act on the findings of the geographic access study to ensure that beneficiaries have realistic access to advertised preferred cost sharing and that preferred networks benefit the Medicare program overall.

**Enhancements and Clarifications on Improving Utilization Review Controls (p.127)**

Although we appreciate and agree with the desire to prevent improper use of risky medications and to ensure that Part D sponsors provide payment only for Part D covered medications, we are concerned about increasing usage of point of sale (POS) edits, including prior authorization requirements, to achieve these ends.

One area of serious concern is excessive use of these edits during transition periods. Given the lack of compliance with existing transition fill requirements,[4] and previous attempts to address failures to properly effectuate transition fills,[5] we strongly urge CMS not to encourage or require the use of POS edits during this vulnerable time.

Advocates also are seeing that transition protections meant particularly for individuals facing safety edits are not proving effective. We refer specifically to Chapter 6, Section 30.4.8 of the Prescription Drug Benefit Manual:

> A Part D sponsor does retain the authority to deny access to quantities or doses during transition (i.e., where clearly articulated safety limits established by the FDA or based upon the same peer reviewed medical literature or well-established clinical practice guidelines used by the P&T committee in formulary management have been exceeded). Prior to implementing such a denial, a Part D sponsor should ensure and track that both: (1) an initial transition supply has been provided up to the maximum limit, and (2) the sponsor has assisted the beneficiary or physician in filing an exception or that an exception has been processed.

We know of at least one plan that has asserted that this requirement does not apply to transition period safety edits that are therapeutic duplication edits, claiming that a therapeutic duplication edit is not a quantity or dose restriction, even though the result at the pharmacy is the same, that is, the beneficiary leaves without needed medication that she has been stabilized on for years. (One case involved a beneficiary who had been stabilized on a combination of

[4] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/ContractYear2013PartDTransitionMonitoringProgramAnalysis.pdf.
[5] http://www.ncpanet.org/pdf/leg/feb12/2011_program_audit_findings_best_practices.pdf.

long-acting pain medications.) Further, we are not seeing evidence of the kind of proactive assistance to enrollees by plans envisioned by the guidance.

Therefore we ask that, to the extent that CMS continues to permit safety edits during transition periods, the agency clarify in the call letter that:

- Any safety edit denial of a continuing prescription during a transition period triggers the protections of Section 30.4.8 of Chapter 6.

- Those protections mean more than the pharmacist handing out the generic notice that is required with any POS denial. Instead, plans must have procedures in place so that the beneficiary can begin the process of getting targeted assistance at the point of sale.

More broadly, the Part D appeals process needs significant repair. Given this, we approach any proposal to implement barriers to medication access with strong skepticism, and we urge CMS to pursue opportunities to streamline and simplify the Part D appeals process.

In 2012, over one third (33%) of calls to the Medicare Rights Center national helpline concerned denials of coverage and appeals, making up the largest proportion of inquiries to the helpline.[6] We find that questions about the Part D appeals process are among the most common and confusing for our callers. Recent findings by MedPAC confirm that many beneficiaries are unaware that they have the right to appeal and do not know how to go about initiating the appeals process.[7]

The lack of individualized information at the pharmacy when refused a medication, long wait times at call centers and inconsistent customer service, an inefficiently managed and overly complex appeals process with a staggeringly high plan reversal rate at the IRE,[8] and problems with plans handling claims that could be covered by Part A or Part B all suggest that POS edits need to be minimized until appeals protections are improved.

**Medication Therapy Management (MTM) Monitoring (p.131)**

We share CMS's concerns, expressed here and in the NPRM that Medicare MTM programs are not living up to desired expectations. While it remains difficult to gauge the relative success of MTM programs, given the lower than expected enrollment and limited evidence of the program's

[6] http://www.medicarerights.org/policy/priorities/2012-medicare-trends.
[7] Sokolovsky, J., Shinobu, S. and L. Metayer, "Part D exceptions and appeals," (Presentation to MedPAC: Sept. 2013), available at: http://www.medpac.gov/transcripts/part%20d%20exceptions%20&%20appeals.pdf.
[8] Excludes cases that were dismissed, withdrawn or remanded and cases involving non-Part D drugs, see: Centers for Medicare and Medicaid Services, "Part D Fact Sheets CY 2011" (2011), available at: http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Reconsiderations.html

efficacy,[9] we support CMS' reminders to plans about their obligations under the program, namely to auto enroll eligible beneficiaries and to provide timely access to MTM services.

**Part D Benefit Parameters for Non-Defined Standard Plans (p.134)**

Once again, we are very concerned that CMS has not increased the dollar amount for drugs that qualify as specialty tier drugs. The price variation of drugs eligible for placement on a specialty tier is very wide, ranging from the $600 threshold to tens of thousands of dollars. Yet, utilization data indicate that most specialty-tier claims are for drugs at the lower end of this price range.

According to the Government Accountability Office (GAO), the utilization-weighted average of the median negotiated price of all specialty tier-eligible drugs in 2007 was $1,100.[10] This raises questions as to why CMS continues to utilize such a low threshold.

Placement on a drug specialty tier can create significant barriers to drug access for beneficiaries. They may be asked to pay more out-of-pocket for the drug than they would if it was placed on a different cost-sharing tier and they cannot seek a tiering exception for such drugs. We strongly urge CMS to both increase in the specialty tier threshold amount, and to engage in rulemaking to allow plan enrollees to seek an exception for specialty tier cost-sharing.

**Antipsychotic Drug Use Data (p.138)**

We share CMS's concern about the pervasive inappropriate use of antipsychotics in nursing homes and the limited progress in curbing the problem. [11] Whether or not antipsychotic drugs remain a protected class for Medicare beneficiaries who have a medical need for such drugs, nursing home residents need protection from the inappropriate prescribing of antipsychotic drugs. Establishing long overdue protections for residents does not depend on changing the rules for antipsychotic drugs for people for whom they are medically necessary.

Although we appreciate that CMS wants to explore various approaches, action is needed now. We urge taking two immediate steps that can be implemented without delay:

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[9] Rucker, L.N., "Medicare Part D's Medication Therapy Management: Shifting from Neutral to Drive," (AARP Public Policy Institute: June 2012), available at: http://www.aarp.org/health/medicare-insurance/info-06-2012/medicare-part-d-mtm-AARP-ppi-health.html.

[10] The GAO's information was based on prescription drug event (PDE) claims data. See, GAO, *Medicare Part D: Spending, Beneficiary Cost-Sharing, and Cost Containment Efforts for High Cost Drugs Eligible for a Specialty Tier* (Jan.2010) http://www.gao.gov/new.items/d10242.pdf.

[11] There is no question that antipsychotic drugs are medically inappropriate for the vast majority of nursing home residents who receive them. The Inspector General conclusively documented in 2011 that hundreds of thousands of residents received antipsychotic drugs and that 83% of the claims were for off-label conditions, including 88% for conditions specified in the black-box warning given to antipsychotic drugs by the Food and Drug Administration (FDA). Office of Inspector General, Department of Health and Human Services, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150 (May 2011), http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf.

- Require plans to implement prior authorization rules for antipsychotic drugs for nursing home residents. Plans know which plan participants are in nursing homes.
- Require plans to implement medication therapy management for all nursing home residents who receive antipsychotic drugs.

**Renewal of LI NET Demonstration (p.140)**

We fully support renewing the LI NET demonstration to continue to ensure availability of access to medications during delays in enrollment for low income beneficiaries.

Thank you for the opportunity to submit these comments.

Sincerely,

Georgia Burke
Directing Attorney
gburke@nsclc.org