JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

March 5, 2018

Submitted electronically to https://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2017-0163
Baltimore, MD 21244-8016

Re: CMS-2017-0163 Advance Notice of Methodological Changes for Calendar Year 2019 for the Medicare Advantage CMS-HCC Risk Adjustment Model and Call Letter

Justice in Aging appreciates the opportunity to provide a response to the above-referenced document.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. We use 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.

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

Section K. Medicare Advantage Coding Pattern Adjustment (p. 35)
CMS proposes setting the Medicare Advantage (MA) coding adjustment factor to the statutory minimum. This adjustment factor is designed, in part, to offset higher payments made to MA plans as a result of more comprehensive diagnoses code recording in Medicare Advantage than is routinely done in Original Medicare.[1]

We share CMS's ongoing concerns about upcoding and continue to encourage the agency to be more assertive with its attempts to control for the impact of differential coding. We particularly ask CMS to closely monitor and collect data to better track the correlation, or lack thereof, between higher coding and provision of more intensive services. Advocates often report that they see high need beneficiaries not getting the services that would optimize their health. Our fear is that for many of these individuals the gap between how their conditions are coded and the actual services that they receive is substantial.

[1] According to MedPAC, average risk scores grew 9% faster in MA than in Original Medicare for comparable beneficiaries. MedPAC, "Medicare Advantage: Status Report" (Dec. 10, 2015), available at medpac.gov/docs/default-source/meeting-materials/december-2015-meeting-presentation-the-medicare-advantage-program-status-report.pdf?sfvrsn=0.

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Attachment VI. Draft CY 2018 Call Letter

Section I, Parts C & D

Annual Calendar (p. 100)

We note that the Calendar continues the requirement that plans mail the Annual Notice of Change (ANOC) and the Evidence of Coverage (EOC) together. In our comments to the proposed Part C & D regulations[2] and in multiple other communications with CMS, we have supported separate mailings of these documents and we repeat that support here. This change would allow beneficiaries to examine the documents separately rather than be overwhelmed by them in the same mailing. In particular, it would encourage beneficiaries to focus on the information contained in the ANOC during the process of plan selection.

We also have urged development of more individualized ANOCs that explain how changes will specifically impact the prescription drug and provider coverage relevant to the particular beneficiary. We reiterate that proposal here as well. We strongly urge CMS to begin to prioritize ANOC improvements and begin to work with stakeholders to improve the ANOC, EOC, and other standardized materials used during the annual election period.

Removal of Measures from Star Ratings

Beneficiary Access and Performance Problems (BAPP) (Part C & D) (p. 112)

We oppose the removal of the BAPP measure and urge that CMS revisit its policy on this issue. As we have consistently argued to CMS,[3] disconnecting the BAPP measure from Star Ratings does not serve beneficiary interests in transparency and does not support fully informed choice. Audits and stars have used different but complementary approaches; however, as these two avenues of oversight and evaluation diverge, the star system may become less valuable to beneficiaries. The continued finding of the same serious deficiencies in audits, deficiencies that directly affect beneficiary access to needed prescription drugs and medical services is of particular concern. Any disconnect between audit scores and the Star Ratings system can be a source of confusion for people with Medicare and professionals seeking to evaluate and compare health plan quality. When CMS determines that a plan's conduct poses a serious threat to the health and safety of beneficiaries, CMS should accurately signal this assessment through Star Ratings, providing beneficiaries with a clear tool that helps them fully evaluate and compare health plans.

If, however, CMS proceeds with removal of the BAPP measure, it is critical that Medicare beneficiaries are better informed in other ways about the organizations' performance issues. We strongly support the use of a low-performing icon or other prominently displayed signal(s) of poor performance.

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[2] See Justice in Aging Part C&D Comments at p. 24, available at justiceinaging.org/wp-content/uploads/2018/01/Part-C-and-D-comments-1-16-2018.pdf.

[3] See Justice in Aging Comments on the 2018 Call Letter, available at justiceinaging.org/wp-content/uploads/2017/03/JIA-Call-Letter-comments-3-3-2017.pdf and Comments on Enhancements to the Star Ratings for 2018 and Beyond, available at justiceinaging.org/wp-content/uploads/2016/12/JIA-Audits-and-Star-Ratings-comments-11-29-2016.pdf.

2018 Star Ratings Program and the Categorical Adjustment Index (p. 122)
We share CMS's concerns that any adjustment for socio-economic or disability status not distort the meaning and value of Star Ratings. We urge CMS to move with extreme caution to ensure that any adjustments do not mask or, worse, reward failures to address the needs of these most vulnerable populations.

New 2019 Display Measure: Plan Makes Timely Decisions about Appeals (Part C) (p. 140)
We support the proposal to include cases dismissed/withdrawn by the IRE in this measure. Doing so would significantly improve the accuracy of this measure. Proper and timely handling of appeals by plans is a core consumer protection. It is important that the measure be as accurate as possible.

Changes to Existing Display Measures: Hospitalizations for Potentially Preventable Complications (Part C) (p. 141)
We support including observation stays in this measure and agree with CMS that observation stays, like other hospital stays, can represent a failure of care coordination to prevent serious complications.

Changes to Existing Display Measures: Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D) (p. 142)
We ask that this measure exclude individuals in palliative care or at end of life, not just those with cancer on in hospice. The situation of these individuals is equivalent to those in hospice or with cancer and it is important that measures do not incentivize denying them appropriate and needed pain relief.

Incomplete and Inaccurate Bid Submissions (p. 157)
We support CMS's continued close scrutiny of bid submissions. At the same time, we encourage CMS to more regularly and thoroughly review plan sponsors' bids for compliance with minimum provider access standards, formulary adequacy, and benefit parameters. Ensuring that plan sponsors meet these minimum standards—at the outset of each year—is critical to ensuring that Medicare beneficiaries have access to appropriate and adequate coverage.

Plan Finder Civil Money Penalty (CMP Icon) or Other Type of Notice (p. 164)
We strongly support the proposal of CMS to include an icon or other notice on the Plan Finder to alert beneficiaries when a sponsoring organization has received a Civil Monetary Penalty (CMP). It is important 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 websites.

We appreciate that CMS responded to advocate concerns and required these disclosures for plans with enrollment suspensions. The same issues of transparency and beneficiary empowerment arise with respect to Civil Monetary Penalties.

We also note that CMS proposed "regular updates" throughout the year. We strongly endorse an approach that updates enforcement actions in real time rather than the current practice of bunching releases of CMPs in February after the annual Open Enrollment Period has ended. Beneficiaries are asked to make market-based enrollment decisions during the OEP and, for those with Special Enrollment Periods, throughout the year. They need full transparency so that they know all the available information about a plan's performance, and they need it in time to make informed decisions. We acknowledge that not every plan sponsor is audited every year and that some monetary penalties are relatively small but these facts do not override the right of beneficiaries to have timely access and to make their own judgments in evaluating information that is undeniably relevant to health care choices.

Further, we ask the 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. See hhs.gov/ocr/newsroom/index.html. 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 (p. 165)
Inaccurate provider directories can mislead beneficiaries when choosing plans and can impede or delay their access to needed providers once they are enrolled. We strongly support vigorous enforcement of directory accuracy requirements.

Medicare Advantage Value-Based Insurance Design Model Test (p. 166)
Noting that the Bipartisan Budget Act (BBA) of 2018 extended the VBID model nationwide, we ask CMS to concentrate on expansion of the VBID demonstration and not simultaneously allow benefit flexibility outside of the demonstration. One of our many concerns is that introducing Medicare Advantage uniform flexibility while the VBID demonstration is still in its early stages will encourage plans to forego participation in the VBID demonstration, thus lessening the opportunities to learn from the demonstration. See our further comments on Medicare Advantage Uniformity Flexibility portion of the proposed Part C and D regulations.[4]

Meaningful Difference (Substantially Duplicative Plan Offerings) (p. 170)
We reiterate our strong objections to the proposal to eliminate the meaningful difference standard, a proposal which would only increase beneficiary confusion and impede reasoned choice among health coverage options.[5] As discussed more fully in our comments to the proposed changes in the Part C and D regulations, we propose that, if CMS believes that there are problems with the current meaningful difference standard, the appropriate approach is to test revisions to the standard rather than abandoning it altogether. Consumer research has shown that beneficiaries already are challenged in

[4] See Justice in Aging C&D Comments, *supra* Note 2 at pp. 10-12.
[5] See Justice in Aging C&D Comments, *supra* Note 2 at pp. 14-15.

making choices among plans, and that their confusion often leads to inertia.[6] Opening the door to additional plan choices without any requirement for meaningful differences among sponsor offerings exacerbates the problem and removes an important beneficiary protection. 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 bid cycle without the opportunity for stakeholders to review or comment on its instructions to plans or other details.

Tiered Cost Sharing of Medical Benefits (p. 181)

We continue to have concerns about the increased complexity of Medicare plan offerings and beneficiary ability to negotiate that complexity. Beneficiaries currently face five or six tiers of prescription drugs, preferred and non-preferred retail pharmacies and, in some cases, preferred and non-preferred mail order pharmacies. In addition, plans can institute tiered cost sharing of medical benefits and/or use a delegation model where, if a beneficiary chooses a provider outside a delegated network, the beneficiary may need to change all other providers.

We ask CMS to closely monitor how tiered cost sharing of medical benefits is actually working and evaluate the beneficiary impact, with particular attention to whether beneficiaries understand their options and are able to navigate choices effectively. Further we ask that CMS examine best practices in communicating tiering and provide specific guidance to plans on how they must present information on the practice.

We also ask that CMS closely examine tiering structures, looking particularly at whether a plan's tiering has a disproportionate impact on access to providers in rural areas, to providers who are language concordant with limited English speakers, or to providers serving low-income neighborhoods.

CMS should always weigh the asserted value of any proposed preferential structure with its effect on beneficiary access, choice and understanding. We ask that CMS systematically collect the data and the information on beneficiary experience that it needs to make such judgments and that it share its analysis with stakeholders.

Health Related Supplemental Benefits (p. 182)

We are hopeful that the broader definition of health related supplemental benefits proposed in the Call Letter will help to appropriately meet member needs and prevent avoidable injury or illness. We believe that, although the 2018 BBA eliminates the requirement that all supplemental benefits be primarily health related, the proposed changes still have the potential to be important and valuable. They cover any plan member, not just those who meet the definition of a chronically ill enrollee. We expect that, for example, there are many frail plan members who would benefit greatly from fall prevention devices but who do not otherwise require intensive care coordination, a need that is part of the chronically ill enrollee definition. Further, the 2018 BBA provisions do not take effect until 2020. The changes

[6] 82 Fed. Reg. 56336, 56363 (Nov. 28, 2017), including references cited in footnotes 27 and 28.

proposed in the Call Letter will give CMS and plans a year in which to start an expansion of supplemental benefits before the additional provisions of the BBA become operative.

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

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

Further, we note that the rationale for giving MA plan members access to items and services that diminish the impact of health conditions and reduce avoidable utilization is equally compelling for all Medicare beneficiaries, not just those who enroll in Medicare Advantage plans. We ask that CMS work to maintain an even playing field between Original Medicare and Medicare Advantage to ensure that effective interventions are equally available to all beneficiaries without regard to how they choose to receive their benefit.

Medicare Advantage (MA) Uniformity Flexibility (p. 184)
We reiterate our belief that flexibility is best tested in the Value-Based Insurance Design (VBID) model and that CMS should not simultaneously introduce outside of the VBID model.[7] The provisions of the 2018 BBA extending the VBID model nationally reinforce these concerns. With a national VBID demonstration, plans in every market will have the opportunity to participate. The VBID model includes consumer protections and evaluation appropriate to a demonstration. We ask that CMS use this demonstration as the vehicle to test uniformity flexibility and urge the agency to not dilute the demonstration by simultaneously offering general flexibility to all plans.

Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs (p. 187)
Integrated Model Materials (p. 188)
We appreciate and support the efforts of CMS to create better and more integrated models of the summary of benefits, the Annual Notice of Change (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

[7] See Justice in Aging C&D Comments, *supra* Note 2 at pp. 10-12.

standard providing the greatest access to individuals with disabilities or limited English proficiency.[8] Dual eligibles who are accustomed to receiving communications about their Medicaid benefits in a language or format they can understand should not have to face the challenge of receiving information from their D-SNP that they cannot understand or use.

- Tailor the notices to the individual's circumstances and include only information directly relevant to the purpose of the notice.

We also ask that CMS continue to work to improve other dual eligible-specific notices beyond those listed in the Call Letter and, more generally, to tailor all its notices to the specific circumstances of the beneficiary. 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 (pp. 190-191)

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 reports we hear from on-the-ground advocates indicate that CMS's efforts have brought broader understanding of QMB protections and more responsiveness by plans when problems arise. The situation is improving but challenges persist. We continue to receive reports both about plan providers who do not understand the protections or are unwilling to honor them and of plan staff who do not understand or fulfill their obligations to protect members. Although we had expected that problems might be most pronounced in smaller plans, we hear from advocates about plans operated by large sponsors that also have key personnel still insisting that that co-insurance is due from a QMB or that an improper billing problem is purely something between the beneficiary and the provider with no plan responsibility.

Thus, we believe that CMS's continued emphasis in this Call Letter on plan obligations to protect their members from improper billing, to educate providers, and to give them the tools to identify QMBs is fully warranted.

We ask that CMS particularly emphasize to plans the need to educate and monitor the performance of all their providers, including pharmacies dispensing Part B drugs and suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Education efforts aimed at the physician

[8] See, e.g., MOU between CMS and California re California Demonstration to Integrate Care for Dual Eligible Beneficiaries, p. 16, available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf.

community do not reach these providers, and we hear from advocates that improper billing issues persist with these groups.

We also support CMS's continued encouragement of plans to establish easy-to-use procedures for providers to obtain up-to-date and accurate information on the QMB status of plan members. As with the provider education component discussed above, these procedures should be available to all provider types, including pharmacies and DMEPOS suppliers, not just physicians.

If CMS encouragement does not fully spur plan action, we urge the agency to use its oversight tools to ensure that plans comply with their obligations. Plans have a very specific duty to CMS, mandated by regulation,[9] to prevent improper billing by their providers. To meet this obligation effectively, plans need to be proactive in establishing standard operating procedures for their providers to check QMB status and in requiring their providers to follow those procedures. It is not enough for plans to just react after-the-fact when improper billing occurs.

We urge CMS to monitor Complaint Tracking Module (CTM) entries to identify plans and plan sponsors that have repeated complaints in order to focus education and enforcement.

Tier Composition (pp. 198-99)
In discussing tiering structure, CMS states that the agency continues to believe that a coinsurance structure is the preferable cost-sharing structure for the non-preferred drug tier. From the beneficiary point of view, we question the value to the beneficiary of a coinsurance structure for any tier. While a coinsurance structure might support reasoned plan selection if drug prices were predictable and constant, the unfortunate fact is that they are not. Plan Finder listing of drug prices can change as frequently as every two weeks and sometimes change dramatically. Moreover, the relative price of a drug in their plan versus other plans can also change significantly. Thus, with a coinsurance structure, beneficiaries have no way to predict their payment liability when choosing a plan or to predict whether the plan they have chosen will continue to be the most appropriate for their needs over the course of the plan year. When beneficiaries can compare plans with set copayments, they are much better able to make informed market-based choices and budget for their health care needs.

Part D Opioid Overutilization Policy (pp. 202-204)
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.

Cumulative Morphine Milligram Equivalent Daily Dose (MME) Safety Edits for High, Chronic Prescription Opioid Users. (pp. 207-212)
We strongly concur with CMS guidance that CMS expects Part D sponsors to "only rely on prescriber

[9] 42 C.F.R. § 422.504(g)(1)(iii).

attestation that the higher MME is medically necessary to approve dosing that is higher than the hard edit when a coverage determination is requested." We also endorse the CMS statement that coverage determinations seeking exceptions to the MME edit should be routinely treated as meeting the criteria for expedited review. It is important that beneficiaries appropriately needing pain management regimens can access needed medications without delay or interruptions.

More generally, we also ask that CMS emphasize to plans, providers, and participating pharmacies the importance of conducting opioid overuse prevention activities in a manner that respects beneficiaries. If beneficiaries believe they are stigmatized or become fearful of interactions with providers, the results will not serve their often complex health needs.

LIS Enrollee Cost-sharing for Out-of-Network Part D Drugs (p. 217)
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 (p. 218)
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 (p. 222)
We continue to appreciate CMS's targeted attention to Medicare-Medicaid plans (MMPs) and the unique needs of their enrollees. We note that the lessons learned and the progress made can have broader applicability to D-SNPs and other Medicare Advantage products.

Network Adequacy Determinations (p. 223)
CMS proposes to 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. Advocates 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. Further, we ask CMS to monitor network adequacy during the plan year, looking particularly at whether providers have left the network and why. From anecdotal advocate reports, we have heard of providers leaving MMP networks once they realized that they would not be able to collect coinsurance from any plan members. This suggests possible gaps in provider education by plans when providers first enroll.

Formulary and Supplemental Drug Files (p. 224)
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 ensure that, for prescription drugs that may be covered under Part D in some circumstances but, when they are not, are covered under the Medicaid program, plans undertake a consolidated review. CMS should ensure that there is adequate coverage and coordination between the formulary and supplemental drug file for these prescriptions. Advocates report that these medications can cause particular access problems. Examples include prescription drugs for cough and cold symptoms, medicines that are frequently used for a medically accepted but not FDA-approved indications, and prescription drugs to affect weight gain.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

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