April 24, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via email to: PartCDcomments@cms.hhs.gov

RE: CMS Request for Information on Medicare Advantage and Part D

Dear Ms. Verma:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on CMS' Request for Information (RFI) seeking ideas to "increase benefit flexibility, efficiency, innovation and more affordable plan choices for beneficiaries" in the Medicare Advantage (MA) and Part D programs.

Before presenting our specific comments, we would like to highlight several of our key concerns and recommendations to address them:

- **Restore Quality Incentive Payments**: ACHP urges CMS to finally correct the substantial losses affecting 2.5 million seniors from implementation of the benchmark cap that has reduced or eliminated quality incentive payments.
- **County Benchmarks Should Be Calculated Based on the Costs of the FFS Beneficiaries Enrolled in both Medicare Parts A and B**: ACHP recommends excluding the costs of the Part A-only FFS beneficiaries from the county benchmark calculation in order to improve the accuracy of the benchmarks.
- **Contract Consolidation and Cross-walking in Star Ratings:** We recommend that CMS maintain the star rating for each separate geographic area or market area, to reduce gaming of the star ratings.
- **Weighting of Star Ratings Measures to Emphasize Clinical Quality:** ACHP urges CMS to improve the weighting of the measures used in the star ratings so that those relating to clinical quality are weighted more heavily than other measures.
- **Accounting for New Enrollees in Risk Adjustment:** ACHP recommends that CMS consider making future changes to the risk adjustment model to account for the costs of new enrollees. Specifically, we urge that diagnoses for these beneficiaries be "concurrent."
- **Telehealth**: ACHP recommends that CMS use its regulatory authority to recognize services

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provided by remote access technologies as covered services**.**

- **Value-Based Insurance Design (VBID):** As CMS moves forward from limited to more expansive demonstrations to test VBID, ACHP recommends that CMS allow plans to offer supplemental benefits that would require care management or disease management participation.
- **Care Delivery Flexibility and Innovation**: We encourage CMS to allow MA plans greater flexibility to incorporate clinical developments, new technologies and small scale pilots that would improve quality and/or reduce costs.
- **Plan Audits**: We recommend that audits be pared to no more than one per parent organization per year (or another reasonable limit on audit or monitoring activity).

ACHP is a national organization bringing together innovative health plans and provider groups leading the nation towards a value-based health care financing and delivery system. Members are non-profit organizations or subsidiaries of non-profit health systems. They provide coverage and care for nearly 19 million Americans, including 2.4 million Medicare beneficiaries. Six of the fourteen 5-star rated MA plans are offered by ACHP members. Overall, 27 MA contracts operated by ACHP members received 5, 4.5 and 4-stars in the star ratings.

I. Medicare Advantage Payment Methodology

a. Restore Quality Incentive Payments

ACHP urges CMS to finally correct the substantial losses affecting 2.5 million seniors from implementation of the benchmark cap that has reduced or eliminated quality incentive payments. CMS should use new authority granted in the President's executive order of January 20, 2017 to:

> "…waive, defer, grant exemptions from, or delay the implementation of **any provision or requirement** of the Act that would **impose a fiscal burden** on any State or a **cost**, fee, tax, **penalty**, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications." (emphasis added)

The benchmark cap clearly meets the test of this executive order as a fiscal burden, cost, or penalty imposed on Medicare Advantage enrollees and health plans. Further, there is bipartisan agreement that the unintended consequence of the benchmark cap provision has been to undermine value-based care and diminish benefits to seniors worth tens of millions of dollars. The executive order, in addition to discretionary language in the law, provides the opportunity to correct this inequity.

CMS continues to interpret the law in a way that is contrary to Congressional intent, denying Medicare benefits to seniors who enrolled in high quality plans specifically so they could take advantage of enhanced benefits. CMS' decision has reduced or eliminated quality payments to plans in about half the nation's counties, affecting 2.5 million beneficiaries. In some areas, 4- and 5-star MA plans may receive the same payment as a 3-star plan, contrary to CMS' goal of paying for value. The benchmark cap interpretation has also limited the effects of CMS' initiative to account for the effects of high enrollment of dual eligibles on star ratings, as achieving a 4-star rating will do little if the plan with high numbers of dual eligibles is in a capped county.

This treatment of MA quality payments stands in stark contrast to other quality programs in Medicare. In other Medicare programs, if a provider meets the required metrics for a quality payment, he or she

receives that payment irrespective of other payment or formula reductions.

Unfortunately, CMS has not used the discretionary authority it has exercised in so many other areas to correct this problem. We continue to believe that the statute allows the Secretary discretion to exclude the quality payments from the benchmark cap calculation. We have previously shared our legal analysis with CMS and would be glad to provide another copy.

CMS states that section §1853(n)(4) of the Social Security Act specifies that the quality bonus payment (QBP) must be included in the benchmark before the comparison is made to determine if the cap is required. However, the language in section 1853(n)(4) directs the Secretary to "take into account" the QBPs, which indicates that the Secretary should *consider* those payments but has the discretion to omit them from the cap calculation. This interpretation of the statute would be consistent with how the "taking into account" language is used elsewhere in section 1853 of the Act and in many other provisions of title VXIII of the Act.

The language used in §1853(n)(4) lacks the level of precision and detail that is used in §1853(n)(l), (2), and (3). In those paragraphs, when Congress sought to establish rules for the calculation of the blended benchmark in terms that plainly limited the Secretary's discretion, Congress used *computational* language. For example, the specified amount is the product of county FFS costs and the "applicable percentage" that applies to all counties in a particular quartile determined under §1853(n)(2)(B). This specific direction is in stark contrast to the language in §1853(n)(4), which directs the Secretary, in determining a blended benchmark amount for an area and year, to ensure that the blended benchmark amount (which for years after 2012 is the specified amount) does not exceed the applicable amount that would otherwise have applied under section 1853(k) for the area and year, *but only after "taking into account" the quality payments* and, presumably, how to continue those payments authorized in the same Act. Had Congress intended for the cap to apply on a plan-specific basis and to be calculated in the manner of a mathematical formula, it could have written a more direct and computational provision.

The discretion allowed by the statute is further strengthened by the President's executive order. ACHP urges CMS to use these authorities to allow full payment of quality bonuses to plans at 4 stars and above in all counties, as intended by Congress.

b. County Benchmarks Should Be Calculated Based on the Costs of the FFS Beneficiaries Enrolled in both Medicare Parts A and B

ACHP recommends excluding the costs of the Part A-only FFS beneficiaries from the county benchmark calculation. This population's costs are likely to be very dissimilar from the FFS population enrolled in both Parts A and B because of the higher cost sharing the beneficiary faces if he/she uses health care services that are not covered by Medicare. If a county has a disproportionate share of these beneficiaries, the FFS costs of the county – and therefore the MA benchmarks – are likely to be underestimated compared to the costs of the MA population which receives both A and B benefits.

We believe that the county benchmarks should be based on a population with similar characteristics to that of the MA population. It is often the case that FFS costs and MA payment rates are compared to each other when there is policy discussion of whether MA plans are paid "fairly." The proposed change, which should be implemented without a requirement for budget neutrality, would make this comparison fairer and more equitable.

MedPAC notes that Part A-only enrollees currently represent 12 percent of the FFS beneficiaries and

that this population is increasing. The share of FFS beneficiaries varies by county, especially in counties with large numbers of Federal retirees, and could have a large impact on a county's benchmark in some instances. In addition, as MA penetration continues to increase, FFS costs in those counties will be based upon a disproportionate share of Part A-only beneficiaries. As a result, without a correction, the county benchmark calculation will be less accurate in representing the overall FFS population.

ACHP recognizes there are several issues which CMS will have to consider. Among them are: whether to recalculate the geographic indices of the past five years based on the new methodology; whether or not to phase-in the change and, if so, over what time period; the effect on the benchmark quartile into which the county falls; and the effect on double bonus counties.

c . Advance Notice Should Forecast the Impact of Rebasing

ACHP recommends that CMS publish an estimate of the impact of rebasing in the annual Advance Notice, even if there are limitations to the estimate. OACT could release a file estimating the upcoming contract year's county benchmark (county FFS costs) using a 4-year average geographic adjuster with the last historical year dropped from the calculation, the same year that will be dropped when the Final Notice is released with final rates. The only data point missing from this calculation would be the latest year that is not yet available at the time of the Advance Notice release. All other data in this file will be updated when the final rates are released in the Final Notice, e.g., USPCCs and adjustments to update the FFS claims data to be more current. The estimate would help MA plans understand some of the impacts proposed in the Advance Notice on the AGA methodology. We assume that these calculations could be performed on the 4 years of historical county FFS claims data that are available at the time of the Advance Notice.

For example, an MA plan located in Miami-Dade county, a fully phased-in county, experienced a decrease of 7.2 percent in its 2017 county benchmark after the 2017 Advance Notice had announced a 2.9 percent *increase* in the national FFS costs per capita. Rebasing was the primary cause of this very large change. Upon further review, the FFS costs in the county's oldest historical year (2009) used to project the 2016 county FFS costs showed significantly higher FFS costs than occurred in more recent years. That year, 2009, is dropped from the 5 year average used in the 2017 county projection. The result is a -7.6 percent change in the 2017 average geographic adjuster. This significant change is difficult to forecast but could be better anticipated if the proposed file is released at the time of the Advance Notice.

We understand that this proposed file of county rates changes in the Final Notice, and some county rates may change significantly when the most current historical year is added to the calculation at the time of the Final Notice. CMS should make clear that this file is a preliminary estimate of the impact of rebasing at the time of the Advance Notice. But we believe that the data would help plans better understand the likely impact of dropping the oldest historical year in the 5 year average geographic adjuster and, overall, help plans forecast the impact of rebasing at the time of the Advance Notice.

d. Rebasing Frequency

We recommend that CMS consider not rebasing every year. Stability and predictability of payment are important attributes of any payment system, and year-to-year changes of significant magnitude are disruptive in setting benefits and premiums. Stability is particularly important for integrated systems, such as many ACHP member health plans, given the capital invested in their owned medical centers and physician offices. After a year in which CMS does not rebase, OACT could use a 6-year (instead of

a 5-year) average of the geographic adjusters to reduce the instability of the county benchmarks. Another approach would be to limit the rebasing change to no more than 2 percent in any given year.

e. **MA Employer Group Waiver (EGWP) Plans**

ACHP encourages CMS to study and analyze the individual bid-to-benchmark ratio by geography to better understand how variable this ratio is by geography. CMS may want to look at this by geographic cohorts that make more sense than using a national factor.

The current approach of separating bid to benchmark ratios by county quartile does not seem to show a significant difference in the ratios in the second, third, and fourth quartiles – 92.2, 93.3, and 93.6 percent respectively. One would expect the bid to benchmark ratios to show a large difference between the lowest and highest county benchmarks, but that seems not to be the case. The methodology makes the calculation more complicated without adding much differentiation. We believe there may be different market forces by geography that affect local plans' bid-to-benchmark ratios that are not reflected by national averages.

f. Normalization Factor

ACHP appreciates that CMS shared the data for calculating the 2018 normalization factor for the CMS-HCC model. It is difficult to predict a change in trend when forecasting from historical data. For future years, we request that CMS describe how the data points reported in the proposed normalization factor section of the Advance Notice are calculated. Given the lag in reporting complete and accurate FFS claims data, calculating risk scores for the forthcoming plan year cannot be done until at least a few months after the calendar year. Because these data point may not be fully credible due to the data lag, we do not believe they should be used in any forecasts. In light of the difficulty of forecasting trends, we recommend an approach that would compute a 5-year average of the historical normalization factors. This approach would minimize the impact of what appears to be any outliers for a given year and allow time for CMS to determine whether that outlier is an anomaly or the beginning of a change in trend. Our proposed methodology is the same type of calculation OACT uses to forecast county FFS costs, except with a longer lag in the FFS cost data (e.g., using 2011-2015 FFS cost data for the 2018 FFS cost projection).

II. Star Ratings

a. Contract Consolidation and Cross-walking

ACHP supports MedPAC's proposal to maintain the star rating for each separate geographic area or market area and we urge CMS to make this change. Bidding and rebate amounts would be based on the organization's star rating in the market area and not on the star rating of the single, surviving contract. Quality results and bonus payments would attach to an individual plan's enrollees in a specific market area, irrespective of the contract configuration.

As MedPAC has pointed out, when contracts are combined under current rules, the surviving contract determines the star rating of the new single contract, regardless of its enrollment size. For example, if two contracts each with 3.5 stars and 100,000 members are consolidated into a surviving contract with 5 stars and only 10,000 members, the newly formed single contract will be designated as having a rating of 5 stars. This means all 210,000 members are now enrolled in 5 star plans for purposes of bidding, quality comparison, and quality bonus payments. The MA plans offered under these contracts can be in different and noncontiguous states. This practice not only costs the Medicare

program, it reduces plan comparability related to quality and provides inaccurate signals to beneficiaries on which to base plan selections.

The current rule for aggregating contracts into a single contract invites this gaming, which is particularly egregious when contracts are in distinct geographic areas and have different star ratings. We understand that CMS would like to reduce the number of contracts to reduce the administrative burden, but the star ratings of individual contracts before the aggregation should remain intact to eliminate artificial inflation of the ratings.

b. Weighting of Star Ratings Measures to Emphasize Clinical Quality

ACHP strongly encourages CMS to improve the weighting of the measures used in the star ratings so that those relating to clinical quality are weighted more heavily than other measures. In addition, we urge CMS to eliminate the "super weight" that is currently applied to improvement measures because it fails to provide an accurate reflection of plan quality. Relatedly, it is important that the hold harmless provision for improvement measures be retained. The higher weighting of improvement measures diminishes the importance of clinical measures and misleads Medicare beneficiaries about which are the highest quality health plans. ACHP plans believe that clinical treatment, prevention, and the satisfaction of a health plan's enrollees are the most important factors in their health care and health outcomes. Measures of those plan characteristics should, therefore, be weighted more than measures assessing plan operations and processes of care.

c. Improving the Stability and Predictability of Star Rating

ACHP encourages CMS to improve the stability and predictability of the star ratings cut points, especially for 4 and 5 stars. If an MA or Part D plan moves from a 3.9 to 4.0 rating, that should reflect a meaningful quality improvement as reflected in the measures used in the star ratings system. The current cluster methodology makes it difficult for plans to forecast their performance and determine the actions needed to improve their star ratings. We recommend CMS consider using a methodology based on national percentiles, similar to the methodology used by NCQA.

Our plans are also concerned about facing "double jeopardy" as a result of CMS' practice of translating the same star measures of low performance into measures of low plan compliance with Medicare requirements. For example, certain appeals measures have been used as part of the CMS audit process. Plans face penalties for the audit findings, while also being penalized in the star ratings due to the audit. The multiple penalties for one audit finding are particularly problematic in the instances where CMS later finds an error in their audit decision, but the plan has already had their Star Rating adversely affected, such as receiving a 3.5 star rating instead of 4 stars. We urge CMS to exclude the audit findings from the star ratings.

d. Coordination of Star Ratings across Medicare Programs

ACHP encourages CMS to coordinate the star ratings measures across Medicare Advantage as well as other Medicare programs, most particularly, those that will be used to assess physician performance under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Health plans and providers should be working in sync to improve the care delivery system and quality measures should help to achieve this outcome.

e. Star Ratings Display Pages

ACHP recommends that CMS provide more detail when publishing data on the display page measures. By providing plans with cut-point and national percentile data on these measures, CMS would allow plans to better gauge their performance relative to others, spurring quality improvement even before the measure appears in the star ratings.

ACHP also encourages CMS not to display new measures of the 5-Star page for at least one year. In addition, any HEDIS measure that is not publicly reported should not be displayed. Once a HEDIS measure is in its second year, it could be considered for display. Only once the measure is in its third year should it be included on the display page and on the 5-Star page. Measures need more than a year exposure so that any weaknesses may be determined.

III. Medicare Advantage Risk Adjustment

a. Improving Transparency in Risk Adjustment Model Revisions

The fundamental purposes of the risk adjustment program for Medicare Advantage is to ensure appropriate resources for the future (prospective) care of Medicare enrollees with health conditions. CMS' risk adjustment models should be developed with the goal of accurate, appropriate payment and ensuring (or at least not discouraging) provision of appropriate clinical care. Its main focus should be on clinical quality and help support accurate payment and stability. However, CMS' process for revising its CMS-HCC risk adjustment models has not been sufficiently transparent and collaborative with health plans; it also should account for different models of care delivery. From the ACHP perspective, increased transparency with respect to the risk adjustment models and any revisions is greatly needed so as to ensure plan confidence in the risk adjustment process. Moreover, because there are fundamental differences in diagnoses coding and payment incentives between FFS and MA, FFS should not be considered as the standard for level of accuracy.

b. Encounter Data as a Diagnosis Source for Risk Adjustment

Given the continued problems of the Encounter Data System (EDS) reporting complete and accurate diagnosis data for the risk adjustment calculation, ACHP urges CMS to not use EDS as part of any blend in developing risk score until major improvements are made. There are too many significant problems with EDS from both a health plan and CMS perspective, as documented in a recent GAO report, *Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments*.

From CMS' perspective, the GAO report found that CMS has not:

- developed requirements for data completeness and accuracy;
- performed statistical analyses to detect certain validity issues;
- reviewed medical records to verify diagnoses and services listed in encounter data; or
- reported what it had learned about data quality to MAOs.

From a health plan perspective, the GAO report found:

- errors in identifying diagnoses used for risk adjustment
- inclusion of encounter data elements considered irrelevant
- technical problems with encounter data submission
- inadequate CMS communication with individual MAOs.

ACHP member plans continue to be unsure whether CMS is properly distinguishing diagnoses that are used for risk adjustment from those that are not used. Our members are not able to fully reconcile encounter data because they have not received all the necessary MAO-004 reports in a timely way. In addition, the EDS is not processing encounters according to current Medicare billing practices, with the result that health plans are not receiving credit for thousands of claims and, consequently, some diagnoses due to these discrepancies. As a result, some plans are seeing as much as a 2 percent reduction in risk adjusted payments compared to reporting under RAPS.

In performing risk assessment and risk adjustment using Hierarchical Condition Categories (HCCs), the diagnoses and demographics of an individual should determine that individual's risk score, no matter what is the data source of that risk score. A plan's prospective costs in the upcoming year are highly correlated to the plan's risk score. That is the purpose of risk adjustment: making payments to plans based on expected future costs for enrolling a certain population. If a data source that reports the demographics and diagnoses is, in fact, accurate, the plan's fully risk adjusted payment should be paid based on that information, no matter the source. Until RAPS and the EDS report diagnoses data in an equivalent way and CMS can show that the two data sources are equivalent, ACHP recommends that EDS <u>not</u> be used for risk adjustment, even as part of a blend for risk score determination.

If CMS continues to use EDS as part of a blended risk score, ACHP proposes the following adjustment: CMS should calculate what the industry risk score average is under 100 percent RAPS and 100 percent EDS, and then calculate the factor that adjusts the EDS risk score up to and equal to the RAPS score. CMS would then apply this factor to the EDS blended portion of each plan's risk score. As an example, if the industry average risk score under RAPS is 1.00, and the industry average risk score under EDS is 0.75, the factor applied to every plan's EDS risk score would be 1.33 (1.00/0.75) as part of the blend.

c. Accounting for New Enrollees in Risk Adjustment

ACHP recommends that CMS consider making future changes to the risk adjustment model to account for the costs of new enrollees. Specifically, we urge that diagnoses for these beneficiaries be "concurrent." In addition to new Medicaid beneficiaries, we suggest that the model's ability to predict costs of the Baby Boomer population, now aging into Medicare, would be more accurate if their risk scores were also concurrent with the payment year. There appears to be some level of pent-up demand for these enrollees, so that a demographic model is less accurate than using concurrent diagnoses. In general, ACHP believes that CMS should consider moving to a hybrid model of prospective and concurrent risk scores for Parts C and D. There are certain high cost diseases such as pancreatic cancer and now hepatitis C that are not captured in a prospective model. Just as a prospective model for a commercial population would miss out on paying health plans for pregnancy, the Part C and D risk models increasingly fall short of recognizing MA plans' costs for treating patients, especially in light of new technology and new drugs.

We also recommend that if a plan has claims information available prior to a person's Medicare enrollment, it could be used for a first year interim risk score. In many cases, a new Medicare beneficiary has no medical claims history on which to base an HCC score. This creates a situation where the plan is at risk for a new beneficiary for the first year of enrollment. However, there are instances where a plan has claims history from other coverage with the carrier that would identify a member's condition or case management participation. If a plan is allowed to use this information for an interim risk score, it would more accurately reflect the risk-reimbursement match that plans seek to ensure accuracy of payment for the level of member risk.

d. Telehealth Encounters

ACHP recommends that telehealth (video) encounters be included as face-to-face encounters for risk adjustment purposes. While we support CMS' policy direction toward counting certain telehealth visits for quality reporting purposes, we recommend that CMS await the evaluation and technical specifications from NCQA, the measure steward. Also, to measure the quality of telehealth/remote access technology encounters, CMS must be able to properly accept and process such encounters, which would require system changes and additional guidance to MAOs.

e. Improving the Risk Adjustment Model

ACHP suggests that MA plan risk adjustment be done on the basis of two years' of diagnoses instead of the current one-year method. We believe that would improve the prediction accuracy of risk adjustment to better account for plan experience.

f. MA Coding Pattern Adjustment

ACHP encourages CMS to share its data on coding trends and variations in those trends by geography, plan type, newer v. older MA plans, and other factors. CMS should provide data on coding trends over the past five years and the methodology used to forecast the 2018 trend. It is especially important for stakeholders to review this data because 2018 is the last year of congressionally mandated coding adjustments. We also encourage CMS to share the raw coding data or a robust sample file. This would facilitate plans being able to self-diagnose whether they are experiencing material differences in health risks of their populations, or if they may have cause for concern on coding practices. Until data is available on coding pattern variations and there is an attempt to understand differences in coding between MA and FFS, ACHP believes there should be no extension of the coding adjustment beyond the 2018 plan year.

ACHP believes that the across-the-board coding intensity adjustment unfairly penalizes MA plans that code conservatively. Further, the adjustment does not take into account what the "right" level of coding is. Many MA plans may be coding more thoroughly and accurately than providers in traditional FFS, whose payment is tied to services and procedures rather than diagnoses.

We note CMS' projection in the fact sheet issued on Feb. 9, 2017 that MA plans on average would realize a revenue gain of 2.5 percent from coding trends. CMS has not shared the data for this projection. After initial steps to improve the collection and reporting of diagnoses, including adoption of electronic medical records, and now that MA plans have years of coding experience, mature MA sponsors have reached a "steady state" of accurate reporting of diagnoses for risk adjustment. Given that, one would expect the coding patterns of MA plans and FFS Medicare to converge, primarily reflecting the illness burden of the population. In fact, we would expect downward pressures on future coding due to the growing enrollment of younger and healthier beneficiaries of the baby boom generation. Also, a number of risk adjustment studies suggest that enrollees who switch from FFS to MA tend to be healthier than their demographic cohort in FFS; that should drive coding down as well.

IV. Telehealth, MA Benefit Design and Cost-Sharing, Including Value Based Insurance Design (VBID)

a. Telehealth

As CMS has indicated, remote access technologies have the ability to "improve access to and

timeliness of needed care, increase communication between providers and patients, and enhance care communication." ACHP members increasingly utilize remote access mechanisms to provide clinical care and strengthen coordination of services across settings; these efforts are enhanced by our members' reliance on an electronic medical record. Medicare leadership and support for innovative clinical approaches relying on remote access technologies would have a substantial impact on the entire delivery system.

CMS has approached this issue by considering remote access technologies to be a benefit, which leads it to cite statutory definitions of covered services and limit any expansion of the use of these technologies to mandatory supplemental benefits. Under this approach, given the reduction in MA benchmarks and the negative update in capitated payments, MA plans are forced to reduce other supplemental benefits or increase premiums, potentially putting them at a disadvantage competitively. ACHP urges CMS to consider remote access technologies to be an alternative modality or complementary means of providing clinical services, not a service itself. Health plans are using remote access, when clinically appropriate, to provide care for their enrollees, and ACHP members are finding very high member satisfaction with this approach and no degradation in the quality of care. Most state Medicaid programs recognize that telehealth is a different way of delivering the covered service – not merely a supplement or complement to face-to-face encounters – so they provide some level of reimbursement for telehealth, particularly for real- time interactive video visits. Many states also require commercial health plans to provide reimbursement for services provided via telehealth, although not necessarily at parity with services provided in person.

ACHP believes that CMS has the regulatory authority to recognize services provided by remote access technologies as covered services. It would appear that the statute does not limit covered services to those provided in a physical location or prohibit covering services when the provider is remote from the patient. In addition CMS' regulation requiring MA plans to comply with coverage requirements under Original Medicare unless those requirements are superseded by Medicare Advantage regulations or guidance. While current guidance in the Medicare Manual specifies that services must be performed in person, CMS has the authority to modify that guidance and permit remote access technologies.

b. Value Based Insurance Design

The existing Medicare Advantage "uniformity" requirement generally requires that an MA plan's benefits and cost sharing be the same for all plan enrollees. Because of this, clinically-nuanced VBID approaches have generally not been incorporated into MA or MA-PD plans. CMS and the Innovation Center are currently conducting a demonstration in a limited number of states of MA VBIDs.

As CMS moves forward from limited to more expansive demonstrations to test VBIDs, ACHP encourages CMS to allow plans to offer supplemental benefits that would require care management or disease management participation. Currently, the VBID Model Test, has coverage of supplemental benefits as one type of intervention and disease management as a separate type of intervention. We believe there would be value in allowing plans to combine the interventions. Beneficiary participation in a disease or care management program can be one of the most effective tools to improve outcomes and manage costs, and VBID can help drive participation and ensure beneficiaries are following their care plans. Being able to fold supplemental benefits into a care management offering has the potential to make VBID even more effective in achieving the goals of improving quality and managing costs. In addition, there may be certain supplemental benefits that are best utilized by beneficiaries under the guidance of a care manager to ensure they are used appropriately.

We also encourage CMS to incorporate into future VBID demonstrations the ability for plans to reduce a member cost share if they engage in an activity or perform in a way that will increase quality, improve satisfaction and reduce costs. Examples would be to reduce the emergency room cost sharing if the member contacts their primary care physician within 24 hours of a discharge so as to encourage follow up, or to reduce a member's cost sharing if they participate in a rehabilitation plan post-surgical procedure such as knee/hip replacement. Such cost sharing reductions would have to be available to all members and communicated when they enroll and annually as part of their plan information. We believe that these initiatives would dramatically reduce the risk for utilization of additional services and improve the member's quality of life. Moreover, these initiatives would encourage the member to take an active role in their own health.

c. Care Delivery Flexibility and Innovation

Currently, MAOs are not permitted to pilot care delivery innovations or deviate from Medicare fee-for-service rules regarding coverage of benefits, even if such efforts would improve quality and/or reduce costs. This makes it more difficult for health plans to incorporate clinical developments and new technologies and thus inhibits innovation and improvements that could spur transformation in Medicare.

To encourage MAO innovation in care delivery, we encourage CMS to:

- Allow plans to enhance care as part of core delivery of original Medicare without having to categorize such services as mandatory supplemental (e.g., plans would be allowed to provide free transportation to facilities for those that meet defined conditions (financial hardship or do not have someone who can meet the requirements for drop off and pick up for surgeries));
- Allow small scale pilots that do not require uniformity of benefits for the whole PBP/contract, plan at risk for the costs;
- Allow MAOs to waive FFS coverage rules (in the direction of being more, not less, generous, e.g. waiving home health eligibility requirements); and
- Allow a provider entity to bear risk for care delivery options that deviate from FFS.

d. Maximum Out-of-Pocket (MOOP) Limits

CMS has noted that the number of MA plans with voluntary MOOPs has decreased significantly over the past several years. We believe the move to the mandatory MOOP can be attributed to the fact that, over time, CMS has reduced the difference in maximum cost sharing by service category between MAOs with the voluntary MOOP and mandatory MOOP. In addition, moving to a higher MOOP is a benefit change that affects only a small segment of the population.

ACHP recognizes that a lower voluntary MOOP benefit helps the frailest and highest cost members. We encourage CMS to continue to incentivize MA plans to offer the lower voluntary MOOP.

We recommend that CMS make some changes to the MOOP values that will strengthen the actuarial incentives for MAOs to offer the voluntary MOOP. First, CMS could change the maximum copays between the two MOOPs on those service categories that have higher utilization by Medicare beneficiaries, e.g., primary care physician, physician specialist, emergency care, and so on. At this time, these services have the same maximum copays under each MOOP. In considering which MOOP to offer as part of their overall benefit package, MA plans will take under consideration which MOOP offers service categories that will allow the plan to charge a higher copay that will result in a larger actuarial value of copayments (utilization multiplied by copays). A plan will be more likely to offer the

Voluntary MOOP if the plan can charge a higher copay, for example, on primary care physician visits under the voluntary MOOP than under the mandatory MOOP because changing that copay results in a significant actuarial value. The more service categories that CMS differentiates between the MOOPs, especially for those services with higher Medicare utilization, the more likely an MA plan will choose to offer the voluntary MOOP.

Second, CMS could move to reduce the dollar difference between the MOOPs. It has been many years since either MOOP has changed from $3,400 or $6,700. Over time, we would encourage CMS to update the voluntary MOOP to a higher value while maintaining the mandatory MOOP at $6,700; an alternative is to update the mandatory MOOP at a lower trend. There are many alternatives for trending the voluntary MOOP. OACT uses the cost distribution of Medicare beneficiaries to currently set MOOP values. Because the MOOP limit has not changed for many years, this suggests that the cost distribution has not changed in many years. To better incentivize MA plans to choose the Voluntary MOOP, we suggest updating the limit by choosing among options such as: 1) USPCC increases; 2) actuarial value of Part A and B cost sharing; or 3) Medicare fee schedules. We would encourage CMS to trend the voluntary MOOP value by also rounding to the nearest $25 and rounding the mandatory MOOP by a smaller amount to ensure the differential between the MOOPs is reduced by a larger amount.

We believe that lessening the difference between the MOOPs, while increasing the copay maximum differentials on service categories that have higher Medicare utilization, will be a strong actuarial incentive for MA plans to move to the voluntary MOOP, a benefit that best serves the frail and high cost/high utilizing member.

e. Preventive Benefits in Medicare Medical Savings Accounts (MSA) Plans

ACHP recommends CMS allow plans to offer first-dollar coverage for preventive benefits in MSA plans to aid in preventive service utilization and for quality metrics. This would be consistent with requirements for Medicare-covered preventive services that do not require cost-sharing.

V. Medicare Advantage Plan Network Adequacy Requirements

a. The Importance of Network Adequacy Standards

ACHP shares the goals of CMS in ensuring that health plan members and patients have appropriate access to care and are able to receive accurate information about their network providers. To achieve those goals CMS has established rules related to beneficiary access and availability, covered services, network adequacy, continuity of care, and provider directories as well as other communications for enrollees.

ACHP recommends that CMS incorporate and recognize in network adequacy standards the improved access to healthcare providers that new technologies are able to deliver. We recognize that current access standards are grounded in the physical availability of providers. However, dramatic changes in the use of visits via email, clinical advice lines, remote consultation by specialists, electronic medical records, monitoring devices, and other aspects of telehealth that enhance access to care suggest that evaluating the adequacy of networks using time and distance alone is becoming an outmoded approach to determining network adequacy. We would like to encourage CMS to engage with stakeholders in an effort to develop new standards that move away from sole reliance on numbers and location of providers. Remote technologies have the potential to increase access beyond solely physical visits.

We understand that CMS will be concerned about maintaining the quality of care when remote access technologies are used. And some of these technologies may not be appropriate for the older segment of the Medicare population, although that will vary with the individual. An additional concern would be the potential for inappropriate use of technologies to increase a provider's reimbursed services, driving up Medicare spending. CMS has quality standards in place that would apply to care delivered through remote access, but could consider additional standards geared specifically towards the quality of remotely-delivered services and monitoring potential fraud and abuse in the use of these services. CMS should also continue to move forward in incorporating quality, value, and customer satisfaction as factors in evaluating network adequacy.

b. Flexibility in Network Adequacy Requirements for Plans Operating in Rural or Certain Other Areas and for Integrated Health Plans

We encourage CMS to consider modifying rules to provide for greater flexibility for rural health plan network adequacy standards. Plans operating in counties that do not have specific specialists have significant challenges meeting certain network requirements. By incorporating flexibility for those plans, CMS would ensure some availability for beneficiaries in rural areas rather than denying those beneficiaries access to MA plans altogether.

Remote access technologies present one of those opportunities to increase access for plans operating in rural areas and that are subject to natural limitations on provider networks and availability of specialists. We ask CMS to consider including the following factors: allowing "home", "other" or "skilled nursing facility" to be allowable places of origin for telehealth and/or virtual visits; allowing these technologies to count towards certain network adequacy standards (e.g. dermatology, allergists, etc.); allowing remote access technology initiatives to begin mid-plan year as long as they are of benefit to the members; including additional types of services within fee-for-service Medicare rather than requiring as supplementary benefits.

We also encourage CMS to relax the time and distance standards in large metro and metro counties, either for all MAOs or for integrated delivery systems meeting a specific definition, allow alternate measures of accessibility if appropriate to the MAO such as appointment wait times, and the percent of providers with open panels. Finally, we urge CMS to make the exception process more flexible and less burdensome for MAOs. The current time and distance standards are too stringent for large and metro counties and do not provide a meaningful measure of actual access to care. Moreover, they can be detrimental to integrated care delivery.

VI. Improvements in MA Administration/Operational Issues

a. Plan Audits

ACHP plans believe that too many audits are carried out under MA (and Part D) and that they present significant burdens and expense to plans because they are not coordinated and overly complex. For the reasons described below, we recommend that the audits be pared to no more than one (or another reasonable limit on audit or monitoring activity) per parent organization per year. In addition, CMS audit activity should be coordinated across CMS divisions (including the Office of Financial Management (OFM)) so that any given parent organization (if audit functions are centralized) is not undergoing more than one audit, monitoring or data validation activity at the same time. Associated data requests should be minimized and the same data requested for one purpose should suffice for other purposes (e.g. appeals monitoring data is the same basic information as ODAG/CDAG but the

specifications are different). In addition, for any given audit/monitoring activity, as little data, documentation, etc. as needed should be requested. No extraneous data should be requested, and data requests themselves should be kept as simple and straightforward as possible to achieve the goals of the audit.

Our rationale for these recommendations is that the current federal government audit/enforcement activities take many forms, including program audits, data reporting/validation, targeted reviews, monitoring, assessments, and projects. These functions all implicate the same individuals in the MAO, whose time is not intended to be spent entirely on those activities. Data "universes" are highly prescriptive, complex and not always clear, even to auditors/contractors, and extraordinarily taxing to create and validate. Not all of the data are used (and are thus unnecessary) and in the experience of some of our plans, the full universes do not produce any better or more accurate results than the statistically valid samples that were used years ago. The "3 strikes" rule (sampling 5 cases within universe to validate the universe) is unduly punitive and burdensome. Changes in protocols can require IT and system updates, which adds time and costs.

Beyond the program/operational type audit activities, there are financial audits including OFM 1/3 financial audit, bid audits, and hospital and HMO cost report audits, which often implicate some of the same individuals who handle audit/monitoring work. The overall concern is that compliance professionals are unable to do the day-to-day work of ensuring member service and protection if they are constantly diverted to attend to audits, data production, site visits, and the like. The recommended modifications to the audit and data reporting processes identified above would not only streamline enforcement and make it more effective; it would help MAOs invest their resources in care delivery.

b. Translation Services

Plans would find it extremely helpful if a limited number of translation vendors could be "pre-approved" by CMS and allow for plans to contract with them. The quality and cost of these vendors vary widely and the beneficiary experience could be improved if pre-approved vendors were identified for these services.

c. Electronic Availability of Communications

In an effort to reduce paper and mailing costs, ACHP suggests that beneficiaries be required to receive MA and Part D plan communications electronically as the primary source of receipt. Those beneficiaries who wish to receive paper copies could be allowed to opt out of the electronic version. At a cost of over $15 to produce and mail each contact, this would be a significant savings to program and eliminate misdirected/undeliverable mail.

VII. Part D

a. Part D Benchmark Release

ACHP member plans that sponsor Part D plans have observed that the recalibration of the Part D benchmark and the current need for plans to revise their plan bids and/or benefits creates an unnecessary administrative burden since the revisions are required within a very short timeframe (four days). Several options merit consideration. CMS could:

- Make the current requirement optional that plan sponsors revise their Part D plan benefits/ premiums as a result of the Part D benchmark release.

- CMS could release a safe harbor assumption on the Part D Direct Subsidy that could be used in bid development. Plan sponsors could elect to take risk that the final benchmarks are materially different if they adopted the safe harbor assumption.
- CMS could widen the corridor (difference between assumed and final Part D benchmarks) under which no adjustments would be required.
- CMS could provide for a preliminary release of Part D benchmarks (once all bids are submitted) and allow plans more time to anticipate required changes.

b. Improving Clinical Decision-Making for Certain Part D Coverage Determinations

We recommend that CMS expand the extension to adjudication timeframes in certain limited circumstances so that it not be limited to weekends and holidays. Some ACHP member plans have experienced challenges in getting prescribers to respond in a timely manner to requests for supporting statements. Under the current rules, many coverage determination requests are denied for lack of information, despite a plan's outreach efforts and even though the request did not fall on a weekend or holiday. In situations in which a PA or ST request is received on a weekday, and the supporting statement is missing, we recommend that the extension should allow plans to toll the clock to provide additional time for outreach and/or for the prescriber to respond. This would be in line with the current tolling process for exceptions. From a beneficiary perspective, our recommendation would decrease the number of denials based on lack of information and avoid having to proceed to the redetermination process, with its longer maximum adjudication timeframes.

c. Part D Out-of-Pocket Cost (OOPC) Modeling

The prescription drug landscape is changing quickly and patent expirations give rise to less expensive generic drugs that will be offered at significantly lower costs. The current OOPC tool uses the most current complete year of experience to set average drug prices, but fails to account for brand drugs that lose patent exclusivity in the current year or those loosing patent exclusivity in the projection year. These drugs can have a large impact on the OOPC calculation and can result in plans adding back drugs that are or were launching generic alternatives. ACHP recommends that CMS revise the OOPC tool to account for brand drugs that lose patent exclusivity in the current year and those drugs losing exclusivity in the projection year.

Thank you for your consideration of ACHP's recommedations. If there are questions or the need for additional information, please contact Howard Shapiro, ACHP Director of Public Policy, at hshapiro@achp.org.

Sincerely,

Ceci Connolly
President and CEO