



August 9, 2019

Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Attn: **CMS-6082-NC**  
Submitted via [www.regulations.gov](http://www.regulations.gov)

**Re: Request for Information; Reducing Administrative Burden to put Patients over Paperwork**

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the Request for Information; Reducing Administrative Burden to put Patients over Paperwork.

ACHP is a national leadership organization bringing together health plans and provider organizations that are among America's best at delivering affordable, high-quality coverage and care. Members are active in 34 states and the District of Columbia, providing both private and public coverage to nearly 22 million Americans, including 2.6 million Medicare beneficiaries.

ACHP applauds CMS' continuing efforts to increase regulatory flexibility and eliminate outdated or burdensome requirements for clinicians, providers, patients and their families. ACHP offers the following recommendations to increase quality of care and make the health care system more effective, simple and accessible.

**Medicare Advantage (MA) Quality Bonus Program (QBP)**

ACHP strongly supports the recognition of quality care for MA plans under the QBP. Certain features of the existing program, however, undermine its ability to effectively target the highest quality plans and impede the program's incentives for quality to work in the best interests of beneficiaries, plans and the federal government. We encourage the Administration to address the following QBP concerns:

***CMS should eliminate topped out process measures and reduce the number of process measures overall.***

ACHP agrees with the Medicare Payment Advisory Commission (MedPAC) that there has been a proliferation of measures which yield limited information to support clinical improvement and dilute quality measurement results. Too many measures overall, and too many process measures in particular, increase the documentation and reporting burden for plans and providers with little to no benefit to the patient. Instead, ACHP supports efforts that build upon the best practices proven by our member plans. ACHP members are community-based, non-profits that have successfully delivered better value through

relationship-oriented practices focused on alignment of goals, improving quality and supporting changes through appropriate financial incentives. ACHP and its member plans look forward to the opportunity to work with CMS to develop measure concepts that flow naturally from these best practices for health plan and provider collaboration to deliver greater value.

***Eliminate gaming of star ratings through contract consolidation.***

ACHP supports the recent efforts of CMS and Congress to eliminate the manipulation of star ratings via contract consolidation. Under the Bipartisan Budget Act of 2018, a combined MA organization can only receive the weighted average star rating of the combined contracts instead of the ratings of the highest-rated contract. Some MA organizations continue, however, to obtain unwarranted bonuses by combining lower rated contracts with higher rated contracts. This practice is particularly troublesome when contracts are in distinct geographic areas and have different star ratings. The focus on gaming star ratings and not providing the high-quality care that the star ratings are intended to recognize is a burden to the plans who are focusing on achieving all around top quality ratings. ACHP supports MedPACs long-standing recommendation that Medicare should collect, calculate, and report quality measurement results at a local geographic level to ensure that real quality is rewarded.

***Fully restore quality incentive payments.***

ACHP shares CMS's concern (outlined in the CY 2020 Rate Notice) that the benchmark cap diminishes incentives for MA plans to continuously improve the care provided to Medicare beneficiaries – a primary goal of the Star Rating system. In that notice, CMS also stated that they had not identified discretion under the statute to permit the agency to administratively eliminate the cap nor exclude bonus payments from the cap calculation.

Including quality payments in the post-ACA benchmark calculation has reduced or eliminated quality incentive payments in half of all counties, affecting more than 2.5 million beneficiaries. The unintended consequence of the benchmark cap provision has been to undermine value-based care, disincentivize quality and diminish benefits to seniors worth hundreds of millions of dollars. This hinders the ability of plans that are dedicated to providing their beneficiaries with high quality and affordable care. The quality bonus program with its rebate dollars is the best way for our plans to accomplish innovative reforms to improve care and access.

We believe that the statute allows the Secretary discretion to exclude the quality payments from the benchmark cap calculation, consistent with their treatment in other Medicare quality programs. 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. Importantly, we recognize the practical limitations – and broader fiscal concerns – of eliminating the benchmark cap entirely and therefore support only removing the quality payments from the calculation in which pre-ACA benchmarks are compared to post-ACA benchmarks. We shared our support with HHS Secretary Azar at a June 15, 2019 meeting with members of ACHP's Board. Secretary Azar requested the legal opinion and asked the Immediate Office of the Secretary to look into the status of our legal analysis and identify options for relief could be provided.

**MA Benchmark Calculations**

***Improve the accuracy of MA benchmark calculations.***

Presently, MA county benchmarks include the costs associated with fee-for-service beneficiaries enrolled in Part A-only as well as those enrolled in both Parts A and B. As MedPAC has identified, Part-A-only enrollees may differ from beneficiaries enrolled in both Parts A and B in ways that make their health care costs systematically different. Including physician spending and Part B services for these enrollees when calculating benchmarks results in lower and inaccurate county benchmarks than would occur if they were calculated using a comparable population. We urge CMS to exclude those individuals in setting benchmarks for MA plans as recommended by MedPAC. The commission also indicated that this correction can be accomplished through administrative action. Leaving the county benchmark calculations as is unduly forces plans to do more with less, which strains their ability to provide high quality care to their beneficiaries.

### **Reduce Multiple Plan Audits and Duplicative Requirements**

#### ***Eliminate multiple, overlapping, and complex MA and Part D plan audits.***

ACHP commends CMS' recent change to eliminate unnecessary compliance training obligations. To further reduce administrative burden, we encourage CMS to take parallel actions to pare down audit activities so that each parent organization faces no more than a manageable number of audits each year. Our suggestions for increasing the efficiency and effectiveness of audit and data reporting processes for CMS and plan sponsors include:

- Better coordinating audit activity across CMS divisions (including the Office of Financial Management and Center for Program Integrity) so that any given parent organization is not undergoing more than one audit, monitoring or data validation activity at the same time.
- Eliminating repeat financial audits for plans with no problematic findings.
- Accepting the financial findings of the independent audit firms from MA annual audits.
- Minimizing associated data requests, requesting the minimum data or documentation necessary, and using the same data for multiple purposes when able. For example, appeals monitoring data provides the same basic information as data for coverage determinations, appeals and grievances but the specifications are different.

### **Medicare Advantage Network Adequacy**

#### ***Modernize network adequacy standards by incorporating telehealth providers.***

ACHP members embrace the use of new technologies that enable increased provider accessibility. Clinicians are able to enhance care by reaching patients despite long distances, responding to patients needs more quickly and monitoring patients' health conditions even after they leave the doctors' office. As these examples show, evaluating the adequacy of provider networks using time and distance alone is an outmoded approach to determining network adequacy. We encourage CMS to engage with stakeholders in an effort to develop new standards that move away from sole reliance on time and distance of providers. This will reduce an undue burden on patients and ease their path to accessing high quality care. The National Association of Insurance Commissioners (NAIC) has recognized in a revised model law that provider network criteria may include "other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care." The Veterans Administration has recently reduced significant barriers to telemedicine for purposes of ensuring providers are available throughout the country, and it serves as a good model.

***Improve network adequacy through benefit flexibility.***

ACHP members and their beneficiaries appreciate the flexibility in the new regulations that allow for telehealth reimbursement and benefit design, especially in rural areas. However, one barrier to improved network adequacy is a plan's inability to add new specialties to the benefits during a current benefit year. We ask that CMS allow plans to add telehealth specialties to their benefits within a current year so that beneficiaries can have access to those services immediately. Without this adjustment, plans must wait until the next bid application to include a new specialty to its telehealth benefits.

**Medicare Advantage Benefits Design**

***Encourage flexibility and innovation in care delivery.***

We support the Administration's recent advancements that increase flexibility for plans offering supplemental benefits and encourage CMS to continue similar efforts. However, in general, MA plans are not permitted to pilot care delivery innovations or deviate from Medicare fee-for-service rules, even if such efforts would improve quality and/or reduce costs. This makes it difficult for plans to incorporate clinical developments and new technologies and inhibits innovation that could spur transformation in Medicare. We encourage CMS to permit plans to enhance the care and services offered as basic benefits rather than categorizing such enhancements as mandatory supplemental benefits and to undertake small-scale pilot projects that do not require uniformity of benefits for the whole plan benefit package or contract.

We also request that CMS consider adjustments to the uniform flexibility implementation timeline. Currently, it is too limited and restricts plans' abilities to process and react. While we appreciate the Administration's overall push toward flexibility and value-based initiatives, we ask that CMS consider offering plans more opportunities to make adjustments throughout the year. Plans should be allowed to build benefits into existing benefit structures at the time they are needed, rather than having to wait until the next bid cycle. This would allow our high-quality health plans to innovate at a speed greater than 18 months out from the bid deadline. For example, if a care management program finds that rehabilitation at home is valuable and wants to provide that service, this would not be possible until the 2021 bids, instead of implementing now, in 2019.

***Address the cost of drugs in Part D.***

We were pleased to support increased flexibility in Part D, including implementing certain utilization management tools such as step therapy for Part D products. We recommend additional policies to address the high cost of drugs in Part D.

In 2016, ACHP submitted a document to CMS entitled "[Barriers and Solutions to Managing Part D Costs.](#)" Some of the issues identified in that document remain problematic, so we urge CMS to consider those recommendations which fall into the following areas:

- Expand upon the ability to make mid-year formulary changes when there are sudden cost increases for a product;
- Facilitate timely updates to formularies to account for FDA approvals or other relevant developments by reducing the gap in formulary submission windows between July and March 1st of the following year;
- Strengthen clinical standards for physician exceptions to formulary requirements;

- Reduce the number of drugs that are considered “protected classes” – for example, removing antidepressants as a defined protected class drug – and clarify in CMS reference files which drugs are considered protected, and
- Allow Part D plans to use split-fill programs for medications that have a higher risk of not being taken for the entire first month.

MedPAC also recommended a number of these policies in the past. ACHP strongly believes that they would help to produce significant reductions in Part D program costs while protecting timely and appropriate access to medications.

### **Member Notification Process**

#### ***Eliminate any unnecessary requirements to provide materials in a written format.***

We ask that CMS reevaluate the regulations that require health plans to respond to “in writing” requests in the same format and encourage CMS to eliminate any unnecessary requirements for plans to provide written information to enrollees. Existing forms of electronic communication can, in many cases, better ensure that beneficiaries receive information promptly, enabling them to react more quickly. Plan enrollees should be given the option to select their communication preferences to accommodate members who do not rely on electronic methods of communication. In many cases eliminating any unnecessary default requirements to provide information in a written format works in the interests of beneficiaries to improve the transparency and timeliness of plan communications. For example, a prior authorization request could be handled more efficiently by calling or emailing the provider as opposed to sending a letter and adding more delay to the notification process.

### **Encounter Data System**

#### ***Remove place of service restrictions in the Encounter Data Processing System***

A number of AHCP member companies offer a broad spectrum of remote access technologies that focus on proactive solutions, real-time analysis and increased continuity of care. Over time, these programs show that they not only save our patients time and money, but also eliminate transportation burden and reduce the cost of care for payers. For example, Marshfield Clinic, the parent organization of Security Health Plan, offers the following programs:

- The Home Recovery Care Program which allows patients/members with specific acute medical conditions to receive hospital-level care in the comfort of their homes or in a Skilled Nursing Facility, at a capped bundled rate. This program is up to 11% less costly than having these services completed in a hospital-based setting.
- Care My Way, a telephonic and video visit service, has served more than 17,000 patients to date seeking low-acuity care. This program has allowed its patients to avoid more than 1,700 emergency room trips and provide care to 4,773 patients that would not have otherwise sought care at all.

The current Encounter Data Processing System follows original Medicare rules, which include strict requirements on place of service. As a result, any innovative services such as those listed above may result in reduced beneficiary risk-adjustment and lower encounter acceptance rate. ACHP requests that CMS validate the encounter data collected in non-original Medicare places of service and allow for its use in risk-adjustment.

Thank you for the opportunity to provide feedback and we look forward to serving as a resource to CMS. If you have questions or require additional information, please contact Michael Bagel, ACHP's Director of Public Policy, at [mbagel@achp.org](mailto:mbagel@achp.org).

A handwritten signature in cursive script that reads "Ceci Connolly".

Ceci Connolly  
President and CEO