



March 1, 2019

Demetrios Kouzoukas
Principal Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted via: www.regulations.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter

Dear Mr. Kouzoukas:

Community Catalyst is pleased to submit comments to the CMS 2020 Advance Notice and Call Letter.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. We have been working to improve Medicaid and Medicare for consumers for more than a decade, including by working with consumer leaders and advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those who are most vulnerable.

We focus most of our comments on sections that impact Medicare-Medicaid enrollees (dual eligibles).

Attachment II.

Section G. CMS-HCC Risk Adjustment Model for CY 2020

Given our focus on care for consumers with complex needs, we recognize the importance of establishing payment models that appropriately capture the complexity of plan enrollees. We appreciate CMS' continued efforts to refine its methodology in this area. We echo the comments

of the SNP Alliance about the need to understand the impact of the changes on specific subpopulations, notably the disabled dually eligible population, and urge further analysis of these issues prior to implementation of the model.

Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs

We appreciate the focus of CMS on the importance of addressing frailty in its payment models. We note the challenges with comparing the average level of frailty in FIDE SNPs to that in PACE. Though most FIDE SNPs have a very large proportion of beneficiaries meeting the institutional level of care definition, these plans often must also accept ALL dually-eligible beneficiaries given state contracting requirements where States mandate that the FIDE SNPs cannot restrict enrollment only to dual individuals who meet an institutional level of care. In contrast, all PACE beneficiaries meet institutional level of care. We question whether CMS could instead include only those individuals who are nursing home level of care in the calculation and apply a proportional adjustment to this population.

As the HOS is used to calculate the frailty adjustment, we also wish to amplify the comments of our colleagues at the SNP Alliance and at ACAP about the limitations of the HOS instrument. We refer CMS to the SNP Alliance's white paper on the HOS, and recommendations to improve the instrument.

Attachment VI.

Section I -- Parts C and D

Enhancements to the 2020 Star Ratings and Future Measurement Concepts

We appreciate CMS' recent increase in weighting for patient access and experience measures. At the same time, we encourage CMS to consider a more comprehensive assessment of person-centeredness that addresses the six dimensions of person-centered care as identified by the Institute of Medicine: be respectful to patients' values, preferences and expressed needs; be coordinated and integrated; provide information, communication and education; ensure physical comfort; provide emotional support; and involve family and friends. Few of these dimensions are reflected in the current star measure set.

2020 Star Ratings Program and the Categorical Adjustment Index

We appreciate CMS' recognition of the impact of how social and economic factors can contribute to health outcomes. We are supportive of efforts to identify measures that are sensitive to the composition of plan enrollees and identify whether those measures should be adjusted accordingly. We also support CMS' plan to test inclusion of stratifications by age, gender, dual eligibility/LIS status, and disability status. Adjustment and stratification serve different purposes and we believe that both have a role in creating a system that balances fair recognition of plan performance with an on-going commitment to reducing disparities in care.

New 2020 Display Measures

Transitions of Care

We are pleased to see a measure focused on transitions of care, as transitions are occasions where communication, coordination and continuation of services and care are critically important. However, the allowed time frame for follow-up and for medication reconciliation (30 days) is far too long, as there can be significant disruption of care in this window. We recommend that these both be completed within a week. We further note that these measures of

transitions of care do not reflect patient experiences, and in the future, would encourage inclusion of questions such as those from the CTM-3.

Forecasting to 2021 and Beyond

Health Outcomes Survey (HOS)

We urge CMS to review the white paper published by the SNP Alliance titled: [*Special Needs Plans under Medicare Advantage Quality Measurement: A Focused Look at the Medicare Health Outcomes Survey \(HOS\)*](#). The White Paper describes the limitations with HOS and offers recommendations for improvement.

Potential New Measure Concepts

Patient-Reported Outcome Measures

We are pleased that CMS is focusing on Patient-Reported Outcome Measures (PROMs). We are particularly pleased to see patient activation or engagement in the treatment process,¹ goal achievement,² and social supports³ are included among the topics. We would like to also see a focus on measuring quality of life and, as noted previously, a more comprehensive assessment of patient-centeredness through the star ratings program.

Section II -- Part C

Medicare-covered Opioid Treatment Program Services Beginning in CY 2020

We support the inclusion of Opioid Treatment Programs (OTPs) in Medicare Part B because it will expand access to medication-assisted treatment (MAT), which is currently the [most effective treatment available](#) for opioid addiction. Adding OTPs to Part B will increase access to methadone, used by [hundreds of thousands](#) of consumers for MAT. Methadone is subject to unique [dispensing requirements](#) and is only available in OTP clinics, currently leaving Medicare beneficiaries with limited access to this highly effective and commonly used medication for MAT. In addition to MAT, OTPs offer a range of services, including counseling and community-based supports. These are well-established best practices for addressing addiction to opioids and other substances.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

We supported the broader definition of health-related supplemental benefits proposed in the 2018 call letter, and are hopeful that the implementation of Special Supplemental Benefits for the Chronically Ill as authorized by the Bipartisan Budget Act of 2018 will further help plans meet members' health and social needs. This expansion recognizes the important role social needs play in influencing health outcomes and is a positive step forward in providing comprehensive, person-centered care.

¹ See, e.g., Hibbard, J. and Greene, J., *What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs*, Health Aff February 2013 vol. 32 no. 2 207-214 (available at <http://content.healthaffairs.org/content/32/2/207.abstract>); Wasson, J. and Coleman, E., *Health Confidence: A Simple, Essential Measure for Patient Engagement and Better Practice*, Fam Pract Manag. 2014 Sep-Oct;21(5):8-12 (available at <http://www.aafp.org/fpm/2014/0900/p8.html#>).

² See, e.g., Reuben, D and Tinetti, M., *Goal-Oriented Patient Care — An Alternative Health Outcomes Paradigm*, N Engl J Med 2012; 366:777-779. March 1, 2012 (available: <http://www.nejm.org/doi/full/10.1056/NEJMp1113631>)

³ Heiman, H & Artiga, S. (2015) Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

However, we recognize that implementing these expanded benefits raises a number of challenges and questions and we look forward to working with CMS to ensure supplemental benefits are offered in a way that meets patients' needs and preserves important enrollee protections.

Determining Eligibility

On the question of how to determine which chronic conditions meet the statutory standard, we recommend using a functional assessment as a measure of chronic illness instead of a list of diagnostic codes. Providing too much discretion to plans to determine the definition creates an uneven playing field that is not fair and equitable to enrollees, but a definition that is too limited and narrow potentially excludes chronically ill enrollees who would benefit from access to supplemental services. We believe utilizing a functional assessment, similar to what is currently used to determine eligibility for long-term services and supports in both the private and public sectors, creates an equitable standard that isn't unnecessarily limiting, and it also assures that the supplemental benefits are addressing the need for which they are intended.

We also appreciate the opportunity to weigh in on whether or not CMS should permit consideration of other factors, like financial need, in determining permissible supplemental benefits for chronically ill enrollees. We know that lower-incomes are strongly correlated with higher rates of mortality and morbidity and that people with greater social and economic needs often have poorer health outcomes. Incorporating some indicator of social and economic need into the process for determining who is eligible for supplemental benefits would help ensure the benefits are targeted at the populations who need them the most. However, we recognize that Medicare is not a means-tested program and would strongly urge against creating any new eligibility standard. Pegging financial need to existing categories of beneficiaries, such as individuals who are dually eligible, could be a possible strategy.

Waiving Uniformity Standards

We want to raise one point of caution about how HHS is interpreting the waiver of uniformity standards. The rule states that MA plans can provide benefits that aren't uniform across enrollees as long as the benefit has "a reasonable likelihood of improving that specific enrollee's health or overall function." We strongly encourage CMS to broaden the understanding of this standard to include preventing the loss of function. For certain patients, an improvement in health function or status may not be possible, but the provision of supplemental benefits may be crucial to maintaining their current health status and preventing or slowing further loss of function. There are still significant quality of life, health, and financial benefits to providing these beneficiaries with supplemental benefits and the rule should not be interpreted so narrowly that these patients are ineligible for important services.

Beneficiary Protections

We are supportive of CMS' efforts to ensure beneficiaries rights are protected as SSBCI is implemented. In particular, we are glad CMS has made it clear that supplemental benefits cannot be used as an inducement for enrollment. We are also glad that CMS reminds MA plans that information about supplemental benefits, including limitations on coverage and the process and criteria for eligibility, need to be clearly identified in the plan's Evidence of Coverage (EOC). Additionally we appreciate CMS' reminder that the appeals process for supplemental benefits is the same as other MA provided benefits. We ask that in the final rule, CMS include a stronger focus on beneficiary education and lay out clear guidelines for how MA plans should educate consumers about supplemental benefits, eligibility criteria, and appeals processes.

We also recommend that CMS include transparency and oversight provisions in the finalized rule. We ask CMS to require plans to report information on supplemental benefits provided as well as eligibility for those benefits, and to make this information publically available. Transparency, evaluation, and oversight will particularly important as this is a new provision with complicated implementation questions and potentially unforeseen consequences for beneficiaries.

D-SNP Administrative Alignment Opportunities

We note our continued concern about reliance on default and passive enrollment. Restrictive enrollment policies undermine beneficiary choice. When beneficiaries are in a plan that does not meet their needs, they may experience detrimental effects to their health and well-being. We believe the best way to ensure robust enrollment in a health plan is to offer high quality member experience through comprehensive benefits, a seamless care coordination function, and robust consumer engagement. We believe that CMS should continue to emphasize strong plan performance as a way to drive enrollment, rather than restrictive enrollment policies.

We appreciate CMS' working with states to develop integrated member materials. We also hope that as state-specific documents are developed in Massachusetts, Minnesota and New Jersey, CMS will share these materials and the learning from their development with other states and provide guidance for best practices. We further encourage CMS and states to:

- Work with community-based organizations, including those that represent communities of color and/or non-English speaking beneficiaries, to ensure a robust and coordinated communication process;
- Consumer test all materials;
- Use plain language and a reading level no higher than sixth grade;
- 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 standard providing the greatest access to individuals with disabilities or limited English proficiency.⁴ 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.

Finally, we are pleased to see that for those D-SNPs whose membership is exclusively comprised of dually-eligible individuals who are exempt from Medicare cost-sharing, CMS is providing the opportunity for plan materials and the Medicare Plan Finder to reflect the \$0 cost-sharing.

⁴ 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](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf).

Medicare-Medicaid Integration Efforts

We understand that CMS is seeking comments on the operational challenges that MA organizations or states may face in accessing the outlined administrative mechanisms for Medicare-Medicaid integration, clarifications on relevant policies in future guidance, and additional administrative alignment initiatives. We note that active involvement of consumers in the design, implementation and improvement of care is important for improving member experience in the plan. In future guidance, we encourage CMS to:

- Require D-SNPs to have consumer advisory councils (CACs)
- Publish an annual report highlighting the status of the CACs, the issues brought forward by the CACs, and the plan response to resolve these issues.
- Collect and report data from CACs on outcomes and impacts of their work. .

We also support the recommendations submitted by Justice in Aging, including on the following issues:

- Institute an ombudsman program for D-SNPs similar to what exists in the Financial Alignment Initiative. This can help address individual issues and address systemic problems (e.g. barriers to integration/alignment).
- Implement contract management teams as CMS has done with states participating in the Financial Alignment Initiative to help monitor alignment issues.
- Address Durable Medical Equipment (DME) alignment: We urge CMS to take steps to ensure that beneficiaries in D-SNPs have access to DME under both Medicare and Medicaid.
- Align supplemental benefits with Medicaid coverage: We have seen situations where supplemental benefits offered by D-SNPs or other Medicare Advantage plans have overlapped with Medicaid-covered services or otherwise created difficulties for individuals who also have Medicaid benefits.
- Ensure language access: In the dual eligible demonstrations, the three-way contracts required that translation requirements for beneficiary communications meet either state or federal requirements, whichever were most beneficial to the enrollee. We suggest similar practices in D-SNP communications.
- Improve alignment of business practices: In the dual eligible demonstrations, we saw significant problems in alignment of business practices between providers of Medicaid-covered services and demonstration plans. We appreciate that CMS has supported technical assistance in these areas and urge continued attention to these issues, including specific guidance to plans on their obligations to identify and work out technical issues with contracted providers before, rather than after, commencing services to beneficiaries.

Finally, we are pleased that the Bipartisan Budget Act of 2018 designates the Medicare-Medicaid Coordination Office (MMCO) as the point of contact for states on D-SNPs and Medicare-Medicaid integration. We appreciate and look forward to the ongoing collaboration that MMCO has with national, state and local consumer groups.

D-SNP “Look-alikes”

We believe that D-SNP “look-alike” plans are an impediment to true Medicare-Medicaid integration. We urge CMS to do all that it can to stop marketing of these products which do not genuinely serve the needs of dual-eligible individuals. These plans have had negative impacts on

beneficiaries and providers, and hindered progress toward truly integrated programs for dually-eligible individuals.

We urge CMS to work to eliminate look-alikes or curtail them as much as possible. We stress that the rise of look-alikes and their negative effects on beneficiaries and on integration efforts is the result of plan actions, not beneficiaries, and that efforts to fix the problems should focus on plans. We are concerned that some solutions proposed by some D-SNPs and demonstration plans penalize beneficiaries, such as through more passive enrollment, beneficiary lock-in, and less beneficiary choice.

As the Call Letter notes, CMS can use its authority under 42 C.F.R. 422.2268 to prohibit misleading communications by plans. We also urge that CMS, by regulation, use the broad authority under 42 U.S.C. 1395w-26(b), to rein in look-alikes. We support CMS' commitment to closely monitor look-alike marketing both for misrepresentations and for possible violations of non-discrimination requirements. We support the detailed recommendations made by our colleagues at Justice in Aging.

Parts A and B Cost-sharing for Individuals Enrolled in the QMB Program

We appreciate that CMS continues its efforts to obtain full plan compliance with requirements to protect QMBs from improper billing. We are also pleased to see a new method for plans to notify pharmacies of a member's QMB status. Given the on-going challenges faced by beneficiaries, we believe that CMS' continued emphasis in this Call Letter on plan obligations to educate providers and to give them the tools to identify QMBs is fully warranted.

Medicare Advantage Organizations Crossing Claims over to Medicaid Agencies

We agree with CMS that the current system—or more precisely, lack of a system—for handling crossover claims from providers in MA plans creates serious challenges. We believe that extending the automatic claims crossover process from MA plans to the appropriate Medicaid secondary payer seems more practical and less burdensome than requiring each provider to navigate the system independently. We note that in the FAI demonstration, crossover claims were able to be eliminated due to the integrated financial model. We recommend CMS review detailed comments and suggestions on this topic submitted by Justice in Aging.

* * *

We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues in the future. Please do not hesitate to contact me at ahwang@communitycatalyst.org with any questions. As always, thank you for your time and attention to these issues.

Sincerely,



Ann Hwang, MD
Director