



April 24, 2017

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

Dear Administrator Verma:

I write to offer the comments of the National Coalition on Health Care (NCHC) in response to the Request for Information on “2017 Transformation Ideas” for the Medicare Advantage (MA) and Part D programs. We greatly appreciate this opportunity to comment on these important issues.

NCHC is the nation’s largest, most broadly representative nonpartisan alliance of organizations focused on health care. The Coalition is committed to advancing—through research and analysis, education, outreach, and informed advocacy—an affordable, high-value health care system for patients and consumers, for employers and other payers, and for taxpayers. Our members and supporters include nearly 90 of America’s leading associations of health care providers, businesses and unions, consumer and patient advocacy groups, pension and health funds, religious denominations, and health plans. Our member organizations represent—as employees, members, congregants, or volunteers—more than 150 million Americans.

Nearly one in three Medicare beneficiaries exercise their option to receive their Medicare benefits through MA Plans and Medicare-Medicaid Plans (MMPs). But in addition to providing important coverage choices, a well-functioning MA program has the potential to advance delivery, payment, and benefit reforms that will improve health care affordability overall.

*NCHC’s comments are aimed at helping Medicare Advantage realize that potential. To summarize, we encourage you to*

- A. Ensure MA payment accounts for the real costs of patient care,*
- B. Align MA with other ongoing efforts to support quality measurement, value, and payment innovation,*
- C. Restore Quality Incentive Payments impacted by the MA benchmark cap, and*
- D. Promote consumer engagement in plan choice and innovation.*

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## **A. Ensure MA Payment Accounts for the Real Costs of Patient Care**

### *Adjust for chronic kidney disease and dementia costs*

Beneficiary advocates and health plans alike have communicated their concerns to CMS that the current risk adjustment approach does not adequately account for care costs incurred by beneficiaries with chronic kidney disease or dementia. Yet this problem has yet to be adequately addressed. CMS should develop and move toward implementation of such adjustments as soon as possible.

### *Apply a frailty adjuster at the beneficiary level to LTSS recipients in all MA plans*

The CMS-HCC risk-adjustment model does not adjust for frailty. For that reason, CMS currently permits Program of All-Inclusive Care for the Elderly (PACE) providers and Fully-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to receive a frailty adjuster. The frailty adjuster is calculated based on these plans' average level of frailty and is applied at the plan level, as opposed to the beneficiary level. PACE providers and FIDE-SNPs are permitted to receive the frailty adjuster because they directly furnish long-term services and supports (LTSS). All other plans, including D-SNPs and Medicare-Medicaid Plans (MMPs), are excluded from receiving the frailty adjuster.

In making this distinction about which plans are eligible for the frailty adjuster, CMS is equating frailty with use of LTSS services. Medicare spending is higher for LTSS users than it is for non-LTSS users. MedPAC and MACPAC have reported that Medicare per user spending is much higher for LTSS users - \$31,921 for institutional LTSS users, \$22,438 for Home- and Community-Based Service (HCBS) state plan users, and \$19,172 for HCBS waiver users – while per user spending for non-LTSS Medicare beneficiaries was much lower (\$14,089 per user).<sup>1</sup> These additional costs are incurred not only by PACE providers and FIDE-SNPs, but also by other SNPs, MMPs, and the full range of other MA plans that enroll LTSS users. But because these other MA plans are not eligible for the frailty adjuster, Medicare payments to these plans do not account for the additional Medicare costs associated with LTSS utilization.

To accurately pay plans that care for LTSS users, CMS should develop a beneficiary-level frailty adjuster for all LTSS users (both institutional and HCBS users) and apply that adjustment to LTSS users enrolled in all other MA plans. This would more appropriately pay plans for the additional Medicare costs associated with LTSS users and would provide plans additional resources to manage the LTSS population. The application of this adjuster should be implemented in a non-budget neutral manner, consistent with current policy with respect to the PACE and FIDE-SNPs.

## **B. Align MA Policy with Other Ongoing Payment and Quality Initiatives**

### *Integrate appropriate behavioral health measures into MA STAR ratings*

Behavioral health comorbidities are strongly associated with greater use of other health care services and higher costs. Yet, throughout the US health care system, there is often little of the coordination between mental health, substance abuse, and other health care providers that is needed for optimal care. Behavioral and mental health metrics can help change this, and in fact, CMS has chosen to include behavioral health measures in other CMS performance measure sets. Many of the best health plans are taking steps to improve behavioral health services across a variety of populations and enhance integration. Yet there now

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<sup>1</sup> MedPAC and MACPAC. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. January 2017.

are not sufficient behavioral health measures in the Medicare Advantage Star Ratings system to support these effective innovations or encourage their adoption elsewhere. Provided the overall measurement burden on plans is not substantially increased, integrating effective substance abuse and mental health measures into the STAR Ratings will ensure MA plans are rewarded for their efforts to improve behavioral health and make behavioral health an integral part of overall care.

#### Count MA risk contracts toward MACRA risk thresholds in 2017

MACRA affords a five percent bonus to those physicians that take risk in Advanced Alternative Payment Models in Original Medicare (including Innovation Center demonstrations and the Medicare Shared Savings Program). Entities must meet certain risk thresholds to qualify for bonuses. Currently, no MA arrangements count toward MACRA's Medicare-only risk thresholds, even if physicians are taking substantially more risk from an MA plan than any Original Medicare models currently offer. CMS should amend its approach in order to count MA risk contracts between plans and physicians for MACRA purposes, beginning with the 2017 performance year. CMS has the legal authority to make incentive payments to participants in MA APMs by deploying the agency's flexibility to test models through the Innovation Center or through the agency's general demonstration authority.

#### Broaden use of telehealth in Medicare Advantage

We note that CMS is waiving various restrictions on coverage of telehealth services both in certain Center for Medicare and Medicaid Innovation (CMMI) models and in the Medicare Shared Savings Program. NCHC generally supports these waivers and believes they can have a positive impact on outcomes and costs. However, in the context of Medicare Advantage, CMS has previously stated that agency is confined to the statutory parameters for telehealth services covered by Original Medicare for purposes of the basic benefit package. As efforts proceed to promote telehealth elsewhere in Medicare, we hope CMS will also pursue administrative strategies to create greater flexibility around telehealth services in Medicare Advantage and work with Congress to remove any statutory barriers that remain. CMS should also explore increasing health plans' ability to test new, CMS-approved technologies that show promise to aid in disease management and patient engagement, such as personalized glucose monitors and blood pressure devices.

#### Issue guidance on the implementation of the new Medicare Diabetes Prevention Program in Medicare Advantage

NCHC strongly supported the recent expansion of the Diabetes Prevention Program and its ongoing implementation as a benefit under Medicare Part B. To date, CMS' outreach has been targeted to providers in traditional Medicare. MA plans lack guidance as to whether or how the benefit will be implemented under Medicare Part C. We urge CMS to clarify these issues as soon as possible.

#### Expand the MA VBID demonstration to all 50 states and Puerto Rico

NCHC supports expanding the MA Value Based Insurance Design (VBID) Model to all fifty states and Puerto Rico.

#### Change the definition of allowable supplemental benefits

More flexibility is needed to include a wider range of supplemental benefits that support upstream interventions directed at targeted conditions or populations. When properly targeted, interventions like nutrition support, social services and transportation can reduce downstream medical costs and improve health outcomes. For example, a pilot program in Medicare Advantage spanning 36 states and 135,000 beneficiaries showed the value of helping a senior gain access to regular healthy meals after a

hospital discharge, resulting in health care savings averaging 31% per member per month for the first month following discharge.<sup>2</sup> Currently, health plans can only use their rebate dollars to provide a relatively narrow definition of health-related supplemental benefits, limiting their ability to target benefits and forge innovative partnerships with community-based organizations.

*Special Needs Plans (SNPs) should be permanently authorized and given appropriate flexibility*

Despite bipartisan support to permanently authorize SNPs and clear evidence of their efficacy, these specialized plans are set to expire on December 31, 2018.<sup>3</sup> CMS should work with Congress to encourage permanent authorization. CMS should also work with SNPs and beneficiary advocates to identify areas where more flexibility is needed, such as customized high value provider networks, better education and targeting to enroll appropriate candidates, and more flexibility in innovative benefit design.

**C. Restore MA Quality Incentive Payments Impacted by the Affordable Care Act's MA Benchmark Cap**

In most regions of the country, Medicare Advantage plans with four or more stars under the STARS rating system are eligible for quality bonus payments. These plans enjoy an additional incentive to improve the quality of coverage and care provided to their enrolled beneficiaries. However, based on CMS' reading of a provision of the Affordable Care Act requiring that county benchmarks not exceed the pre-ACA amount, many of the highest-performing plans are now denied the full quality bonus payments that their STARS ratings otherwise would have earned. Under any sensible national quality bonus system, the highest-rated plans in the most efficient areas of the country ought to be rewarded. Instead, based on the previous administration's erroneous reading of the ACA, the current approach reduces or eliminates their bonus entirely. This undermines the incentive to improve and innovate in the delivery of care and benefits for beneficiaries. Other commenters have identified existing legal authorities that permit CMS to correct this problem. We urge you as Administrator to revisit this issue and pursue every possible means to correct it.

**D. Promote Consumer Engagement in Plan Choice and Innovation**

CMS' Request for Information (RFI) places appropriate emphasis on "facilitating individual preferences" and ensuring that people with Medicare have "options that fit their individual health needs." CMS should advance policies that encourage people with Medicare to make active and informed choices about the coverage options that are right for them. Additionally, as CMS moves forward with innovative new models in Part C and D like the MA VBID demonstration, a strong consumer role in the establishment, implementation, and evaluation of these models is desirable. The following recommendations are intended to facilitate the achievement of these important consumer engagement objectives:

*Personalize the Annual Notice of Change (ANOC)*

Informed, enabled beneficiaries are essential to well-functioning health insurance markets. To fully evaluate plan choices, people with Medicare need access to more robust support tools.

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<sup>2</sup> Zhu, Huichen, and Ruopeng An. "Impact of home-delivered meal programs on diet and nutrition among older adults." Sage Journals, 10 June 2014. Web. 19 Apr. 2017.

<sup>3</sup> 115th Congress (2017-2018). S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017; Robb Cohen, Jeff Lemieux, Jeff Schoenborn and Teresa Mulligan. Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients. Health Affairs, 31, no.1 (2012):110-119.

The ANOC is one of the most important documents for improving beneficiaries' ability to make wise choices. CMS should take steps to personalize the MA and Part D ANOC for individual recipients so that it explains changes through the beneficiary's frame of reference.<sup>4</sup> We understand that individual plans are taking steps towards personalization regarding medication and pharmacy network changes. We encourage CMS to support broader adoption of these steps. Specifically, we recommend that CMS solicit input from multiple stakeholders on recommendations to improve the MA and Part D ANOC, EOC, Summary of Benefits, and other standardized materials used during the annual election period, perhaps through a more targeted Request for Information.

Further, in the 2018 Final Rate Notice and Call Letter, CMS indicates that MA and Part D plans should continue to disseminate both the ANOC and Evidence of Coverage (EOC) by September 30th.<sup>5</sup> We encourage CMS to revisit its prior recommendation to require separate mailings of the ANOC and EOC for MA plans to bring more beneficiary attention to the ANOC and to extend that recommendation to stand-alone Part D plans. The EOC is long and detailed, and many MA enrollees do not understand it or even read it fully. By contrast, the ANOC is a shorter, more streamlined tool and, more importantly, it is time sensitive.

#### Revitalize the Plan Finder

The Medicare Plan Finder is the premier online tool available to help people with Medicare, family caregivers, and professionals evaluate and compare the MA and Part D plan options available in a given region. While this tool has significantly improved since the inception of the Part D benefit, more can and should be done to enhance the usability of the Plan Finder.

We encourage the agency to establish a long-term goal to incorporate a searchable MA provider directory in Plan Finder that includes both individual practitioners and hospitals. To date, provider network information is not fully integrated in Plan Finder, significantly diminishing its utility for those seeking to compare and contrast MA plan options. Clearer information on cost-sharing and coverage for MA supplemental benefits, like dental and vision care, is also needed. Other improvements could include incorporating better comparison tools, especially related to out-of-pocket costs and comparing Medicare Advantage to Traditional Fee-For-Service (FFS) Medicare, as well as user-friendly sorting capabilities.

In the interim, we urge CMS to engage in a transparent, multi-stakeholder process to solicit input on needed Plan Finder improvements and how best to redesign this important consumer tool. Now more than ten years following the establishment of Medicare Part D, we believe Plan Finder is overdue for a comprehensive update. Any such updates to Plan Finder should leverage existing consumer research work at CMS, and be implemented following comprehensive consumer testing across the array of beneficiary populations in Medicare. With 10,000 people becoming eligible for Medicare each day and MA enrollment on the rise, we encourage CMS to redesign Plan Finder to better meet the needs of a growing population of MA and Part D enrollees.

#### Engage consumers in model development, implementation, and evaluation

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4 "Medicare Part D: Opportunities exist for improving information sent to enrollees and scheduling the annual election period," GAO, 2008, [www.gao.gov/assets/290/284178.pdf](http://www.gao.gov/assets/290/284178.pdf).

5 "2018 Medicare Advantage and Part D Advance Notice and Draft Call Letter," CMS, February 1, 2017, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-01.html>.

Through the Centers for Medicare & Medicaid Innovation, CMS solicited input on and then finalized two health plan innovation models, the Medicare Advantage Value-Based Insurance Design (MA V-BID) model and the Part D Enhanced Medication Therapy Management (MTM) model. As a multi stakeholder coalition, NCHC believes soliciting this kind of input from the full range of stakeholders can contribute greatly to CMS' reform efforts. But engagement of beneficiaries and their advocates is particularly important to transformation initiatives' sustainability and impact. As the Agency proceeds, we urge CMS to create mechanisms to ensure beneficiaries and their advocates are involved in the development, implementation, and evaluation of these models. Towards this end, we recommend the following actions:

- Convene regular meetings of a consumer and patient advisory council;
- Create multi-stakeholder advisory panels on specific delivery and payment models;
- Involve beneficiaries and their advocates in Technical Expert Panels (TEPs);
- Solicit public comment on proposed model designs;
- Regularly engage beneficiaries and their advocates as new models are implemented;
- Publicly release all data, metrics, outcomes, and evaluation findings for each model;
- Enhance support for beneficiaries via 1-800-MEDICARE and State Health Insurance Assistance Programs (SHIPs); and
- Carry out beneficiary testing and readability reviews of patient-facing content for each model.

*Create the Alternative Payment Model (APM) Ombudsman*

We support CMS' commitment to creating an Alternative Payment Model (APM) Ombudsman to monitor the beneficiary experience with existing and emerging CMMI models and to serve as a clearinghouse for patient and consumer information. We expect the APM Ombudsman will play a critical role for MA enrollees in the MA V-BID program, enhanced MTM demonstration, and any other health plan innovations the Agency might pursue.

We greatly appreciate your decision to issue this Request for Information and the opportunity to respond. Should you or your team have any questions with respect to these issues, please contact NCHC's Policy Director Larry McNeely at [lmcneely@nchc.org](mailto:lmcneely@nchc.org) or 202-638-7151.

Yours truly,



John Rother  
President and CEO