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VIA ELECTRONIC SUBMISSION
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Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

RE: 2017 Transformation Ideas

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the Request for Information (RFI) on "2017 Transformation Ideas" for the Medicare Advantage (MA) and Part D programs. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights serves nearly three million people with Medicare, family caregivers, and professionals through its national helpline and educational programming annually.

We are grateful for the opportunity to submit recommendations on administrative policy options intended to strengthen the MA and Part D programs and ensure that they are optimally serving older adults, people with disabilities, and their families. Our comments focus on:

- improving beneficiary supports and education;
- promoting active and informed plan choice;
- maintaining and strengthening oversight;
- simplifying plan-level appeals processes;
- engaging patients and advocates in innovation; and
- achieving payment accuracy in Medicare Advantage.

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This input is informed by Medicare Rights' experience counseling nearly 20,000 clients and educating nearly three million Americans about Medicare each year. In particular, our recommendations draw from multiple years of analysis on the most common challenges facing callers to our national helpline, and we highlight key helpline trends throughout our comments.[1] For questions or additional information, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org org or (202) 637-0961 and Casey Schwarz, Senior Counsel for Education and Federal Policy, at cschwarz@medicarerights.org or 212-204-6271.

IMPROVING BENEFICIARY SUPPORTS AND EDUCATION:

Like all forms of health insurance, Medicare can be confusing, complicated, and even overwhelming to navigate, and our firsthand experience serving people with Medicare suggests that the myriad options available through MA and Part D can make it even more so. A series of focus groups conducted by the Kaiser Family Foundation validates much of what we hear on our national helpline. According to the findings, "Seniors say they found it frustrating and difficult to compare plans due to the volume of information they receive…and their inability to organize the information to determine which plan is best for them."[2]

Another analysis determined that, "In 2014, only 11% of MA enrollees voluntarily switched from one plan to another between 2013 and 2014…"[3] And a similar study showed that only 13% of Part D enrollees switched plans each year.[4] Inertia is widespread even though changing plans may lead to lower premiums and cost-sharing for MA and Part D enrollees. But these programs, and taxpayers, rely on beneficiaries to make informed, savvy choices—in other words—to "vote with their feet"—so that competition can reward plan innovations that work, identify bad actors and problematic behaviors, and reduce both beneficiary and program costs.

People with Medicare and their caregivers require adequate, actionable information about each decision point they face—from enrollment to care planning and appeals. A combination of print, online, and individualized, in-person assistance is required to achieve this end. We strongly believe the Centers for Medicare & Medicaid Services (CMS) should strengthen educational tools and beneficiary supports, and we recommend the following:

Support the State Health Insurance Assistance Programs (SHIPs). We are deeply troubled by recent proposals to eliminate federal funding for the State Health Insurance Assistance Programs (SHIPs).[5] SHIPs are the only

[1] For helpline trends for 2012-2015, *see:* "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline" (2014), *available at* https://www.medicarerights.org/pdf/2012-helpline-trends-report.pdf; "Medicare Trends and Recommendations: An Analysis of 2013 Call Data from the Medicare Rights Center's National Helpline" (2015), *available at* https://www.medicarerights.org/pdf/2013-helpline-trends-report.pdf; "Medicare Trends and Recommendations: An Analysis of 2014 Call Data from the Medicare Rights Center's National Helpline" (2016), *available at* https://www.medicarerights.org/pdf/2014-helpline-trends-report.pdf; "Medicare Trends and Recommendations: An Analysis of 2015 Call Data from the Medicare Rights Center's National Helpline" (2017), *available at* https://www.medicarerights.org/pdf/2015-helpline-trends-report.pdf.

[2] Gretchen Jacobson, Christina Swoope, Michael Perry & Mary C. Slosar, "How are Seniors Choosing and Changing Health Insurance Plans?" Kaiser Family Foundation (May 13, 2014), *available at* http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/.

[3] Kaiser Family Foundation, "Few People Switch Medicare Advantage Plans Each Year, Raising Questions About Whether Seniors Have the Tools and Information They Need To Compare Plans" (September 20, 2016), *available at* http://kff.org/medicare/press-release/few-people-switch-medicare-advantage-plans-each-year-raising-questions-about-whether-seniors-have-the-tools-and-information-they-need-to-compare-plans/.

[4] Jack Hoadley, Elizabeth Hargrave, Laura Summer, Juliette Cubanski, and Tricia Neuman, "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?" Kaiser Family Foundation (October 10, 2013), *available at* http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/.

[5] *See*, Senate Appropriations Bill, "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill" (June 9, 2016), *available at*

source free, personalized, unbiased counseling on the growing complexities of Medicare coverage for the 55 million older adults and people with disabilities who rely on the program. SHIPs receive funding under the Administration for Community Living for 54 grantees (including all states, Puerto Rico, Guam, the District of Columbia, and the U.S. Virgin Islands). The SHIP network is comprised of more than 3,300 local SHIPs and over 15,000 counselors, 57% of whom are trained volunteers who donate almost 2 million hours of assistance.[6]

Last year, almost 3.5 million people with Medicare received help from SHIPs. Since 1992, counseling services have been provided via telephone, in-person sessions, interactive presentations, health fairs, and enrollment events. On average, SHIP counselors spend 50 minutes with each client, and over 500,000 SHIP contacts in 2015 lasted more than one hour. Nearly 10,000 Americans become eligible for Medicare each day—significantly increasing the need and demand for SHIP services. Indeed, individualized assistance provided by SHIPs almost tripled over the past ten years.[7]

SHIP counseling encompasses a broad range of areas, including coverage options, fraud and abuse issues, billing problems, appeal rights, and enrollment in low-income assistance programs. As such, SHIPs offer increasingly critical services that cannot be supplied by 1-800 MEDICARE or through web-based and written materials. Approximately one-third of all partner referrals to SHIPs originate from MA and Part D plans, local and state agencies, CMS, the Social Security Administration (SSA), and members of Congress and their staff. In addition, these partners include SHIP contact information in their websites, publications, and correspondence as a leading source of assistance when people need help with Medicare.

SHIPs advise, educate, and empower individuals to navigate an increasingly complex Medicare program and help beneficiaries make choices among a vast array of options to best meet their needs. For people with Medicare, making informed decisions among an average of 18+ prescription drug plans[8] and 19 Medicare Advantage plans,[9] as well as various Medigap supplemental insurance policies, can save money and improve access to quality care. As an example, several states that estimate savings to beneficiaries resulting from SHIP assistance reported achieving significant savings in 2015, including $110 million in Massachusetts, $56 million in Michigan, and $53 million in North Carolina.

For these reasons, we strongly encourage CMS to actively support the SHIPs, and we urge this Administration to revisit a FY2017 funding proposal to eliminate SHIP funding.[10] SHIP counselors are essential to helping people with Medicare make informed, individualized choices about how to receive coverage and care.

Require plan sponsors to create a point of contact/liaison for SHIP counselors. SHIP counselors now have the ability to contact a particular number at 1-800-MEDICARE to resolve some Original Medicare issues. Avoiding

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https://www.appropriations.senate.gov/imo/media/doc/FY2017%20Labor,%20Health%20and%20%20Human%20Services,%20and%20Education%20Bill%20-%20Report%20114-274.pdf. *See*, "White House 2017 Budget Supplement" (March 23, 2017), *available at* http://www.politico.com/f/?id=0000015b-14ec-d040-a17b-bfeea7410001.

[6] Administration for Community Living, "State Health Insurance Assistance Program (SHIP)" (last visited April 24, 2017), *available at* https://acl.gov/Programs/CIP/OHIC/SHIP.aspx.

[7] National Council on Aging, "Funding for Medicare State Health Insurance Assistance Programs (SHIPs)" (June 2016), *available at* https://www.ncoa.org/wp-content/uploads/IB16-SHIP-Funding-June.pdf.

[8] Kaiser Family Foundation, "The Medicare Part D Prescription Drug Benefit" (September 26, 2016), *available at* http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/.

[9] Gretchen Jacobson, Anthony Damico, Tricia Neuman & Marsha Gold, "Medicare Advantage Plans in 2017: Short-term Outlook is Stable" (Dec 21, 2016), *available at* http://kff.org/report-section/medicare-advantage-plans-in-2017-issue-brief/.

[10] "White House 2017 Budget Supplement" (March 23, 2017), *available at* http://www.politico.com/f/?id=0000015b-14ec-d040-a17b-bfeea7410001.

long hold wait times and speaking immediately with a knowledgeable, high-level problem solver is instrumental to fixing problems for beneficiaries quickly and at a low cost.

We recommend that this same access be provided by MA and Part D plan sponsors. Because SHIP counselors are well trained in Medicare rules and guidance, access to a point person employed by the issuer who is familiar with SHIPs and can follow up on casework will help to more expediently resolve enrollee problems. The establishment of MA and Part D sponsor liaisons to SHIPs will not only help counselors and beneficiaries, it may also help plan sponsors more quickly identify trending issues or problematic patterns so that they can be addressed.

Elevate the Office of the Medicare Ombudsman. Through casework, the Ombudsman works to resolve beneficiary problems not addressed through 1-800-MEDICARE and other means and presents systemic challenges facing people with Medicare to CMS, Congress, and the public.[11] This office must be adequately resourced and staffed to meet growing needs. Similarly, it is critical that the agencies administering Medicare are responsive to common challenges beneficiaries present. Working in concert with organizations like Medicare Rights, the Ombudsman can and should bridge policymaking and the lived experiences of people with Medicare.

Improve Notices. Written notices regarding enrollment, plan changes, coverage decisions, appeals, and costs are the most frequent method of communication between Medicare, MA and Part D plans, and beneficiaries. For that reason, CMS should strive to ensure that all notices advance the goals of the Office of Disease Prevention and Health Promotion's National Action Plan to Promote Health Literacy, specifically to "[d]evelop and disseminate health…information that is accurate, accessible, and actionable" and to "[p]romote changes in the health care delivery system that improve information, communication, informed decision-making, and access to health service."[12] The Centers for Disease Control and Prevention also highlight five key points in health literacy:

1. Nine out of 10 adults struggle to understand and use health information when it is unfamiliar, complex, or jargon-filled.
2. Limited health literacy costs the healthcare system money and results in higher than necessary morbidity and mortality.
3. Health literacy can be improved if we practice clear communication strategies and techniques.
4. Clear communication means using familiar concepts, words, numbers, and images presented in ways that make sense to the people who need the information.
5. Testing information with the audience before it is released and asking for feedback are the best ways to know if we are communicating clearly. We need to test and ask for feedback every time information is released to the general public.[13]

To that end, we encourage CMS to develop model notices in consultation with numerous stakeholders. We appreciate the opportunities that the agency currently provides for input on communications to beneficiaries, including the "Medicare & You" handbook and, most recently, the "Welcome to Medicare" materials mailed to individuals automatically enrolled in Medicare. We also strongly encourage CMS to regularly test notices with consumers. Where CMS does not require MA and Part D plans to use model notices, plans should be encouraged to

[11] *See, e.g.*, Centers for Medicare & Medicaid Services Office of the Medicare Ombudsman, "FY 2013 Report to Congress" (2014), *available at* https://www.cms.gov/Center/Special-Topic/Ombudsman/2013-Ombudsman-Report-to-Congress-.pdf.
[12] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, "National Action Plan to Improve Health Literacy" (2010), *available at* http://www.health.gov/communication/hlactionplan/pdf/Health_Literacy_Action_Plan.pdf.
[13] Centers for Disease Control and Prevention, "Talking Points About Health Literacy" (last visited April 24, 1971), *available at* https://www.cdc.gov/healthliteracy/shareinteract/TellOthers.html.

test notices and to report on such testing to CMS. In our experience, notices developed with stakeholder participation, including consumer advocates and/or through focus group testing, are much stronger and clearer.

Finally, CMS should also ensure that notices are available in languages other than English as much as possible. We encourage the agency to adopt the recommendations compiled by our partners, Justice in Aging, to expand the categories of documents subject to translation requirements and to add numerical thresholds to the percentage thresholds for translation.

PROMOTE ACTIVE AND INFORMED PLAN CHOICE:

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." As discussed above, promoting active and informed decision-making among people with Medicare about their coverage options is of paramount concern for the Medicare Rights Center.

We believe CMS should advance policies that encourage people with Medicare to make active and informed choices about the coverage option(s) that are right for them, selecting among Traditional Medicare, Medicare Advantage plans (including integrated Medicare-Medicaid options), supplemental Medigap policies, and stand-alone Part D prescription drug plans. The following recommendations are intended to facilitate this important goal:

Personalize the Annual Notice of Change (ANOC). Our experience shows—and available evidence confirms—that people with Medicare are often confused by the many choices available to them when selecting among MA and Part D plans.[14] 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.

The ANOC is one of the most important documents for improving beneficiaries' ability to make wise choices. We often hear from MA and Part D enrollees who are adversely affected by unanticipated plan changes early in the plan year. As such, we continue to advocate for an individualized MA and Part D ANOC to better serve beneficiary needs, specifically one that details which specific providers or pharmacists are leaving a plan network, which specific prescription drugs are no longer on the plan formulary, and where utilization management tools will be newly applied. Ideally, these customizations should reflect an individual's actual providers, pharmacists, services, and prescription drugs.

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.[15] We understand that individual plans, such as United American and Aetna, are taking steps towards personalization regarding medication and pharmacy network changes. We encourage CMS to test, encourage, and require these steps. At a minimum, 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, such as through a more targeted Request for Information.

[14] Gretchen Jacobson, Christina Swoope, Michael Perry & Mary C. Slosar, "How are Seniors Choosing and Changing Health Insurance Plans?" Kaiser Family Foundation (May 13, 2014), *available at* http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/.

[15] *See,* U.S. Government Accountability Office, "Medicare Part D: Opportunities exist for improving information sent to enrollees and scheduling the annual election period" (2008), available at www.gao.gov/assets/290/284178.pdf.

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.[16] We continue to encourage CMS to revisit its prior recommendation to require separate mailings of the ANOC and EOC for MA and Part D plans to bring more beneficiary attention to the ANOC. The EOC is long and detailed, and many 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.

With regularity, Medicare Rights provides written feedback and recommendations to CMS on how to strengthen the Plan Finder experience, drawing from our experience counseling people with Medicare during the annual enrollment period. These include suggestions related to basic formatting and pharmacy and cost-sharing displays as well as the addition of critical, missing information.[17]

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. Further, we believe CMS should add information on Medigap options to Plan Finder to allow beneficiaries to fully assess the coverage choices available to them. This content should include information on states that allow a guaranteed issue right to Medigap beyond a beneficiary's initial eligibility.

At a minimum, 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 Part D, we believe Plan Finder is overdue for a comprehensive update. 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.

Strengthen consumer protections in "seamless conversion" arrangements. In October 2016, CMS issued a temporary moratorium and released previously unavailable information on seamless conversion, a practice that allows select insurers to auto-enroll an individual currently in one of their commercial or Medicaid products into an MA plan when that person becomes Medicare-eligible.[18] Before the moratorium is lifted, we strongly urge CMS to add stronger consumer protections and transparency to seamless conversion policies. We believe the use of seamless conversion should be limited to ensure that people new to Medicare can make an active and fully informed choice about the coverage option that best fits their needs.

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[16] Centers for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information" (April 3, 2017), *available at* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf.

[17] Medicare Rights Center, "MEMO: Plan Finder Observations (2013-2015)" (September 2016), *available at* http://blog.medicarerights.org/medicare-rights-offers-recommendations-make-medicare-plan-finder-user-friendly/.

[18] Centers for Medicare & Medicaid Services, "MEMO: Seamless Enrollment of Individuals upon Initial Eligibility for Medicare" (October 2016), *available at* https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS_Memo_Seamless_Moratorium.pdf.

CMS' existing policy defaults a person into an MA plan with minimal outreach requirements and no conditions that the auto-assigned MA plan align with a person's needs concerning provider access, coverage rules, and out-of-pocket costs. As such, we urge CMS to adopt additional consumer protections as part of seamless conversion practices, as outlined in our September 2016 letter.[19] These protections include:

- Establishing a write-in confirmation;
- Allowing a Special Enrollment Period (SEP);
- Requiring additional outreach and notification;
- Tailoring notification by conversion type, namely commercial versus Medicaid;
- Regularly releasing data on seamless conversion practices;
- Creating a 1-800-MEDICARE call center script; and
- Publishing CMS' approval criteria and oversight mechanisms.

Importantly, we understand that some individual health plans and their associations have expressed a willingness to entertain some of these requirements, including additional and tailored notice requirements, select data releases, published approval criteria or check-lists, and more. We remain open to a dialogue with CMS, health plans, and other stakeholders that facilitates the development of a consensus policy on how to adequately support and protect people with Medicare who may be seamlessly converted into an MA plan.

Encourage meaningful variation among MA plans and consider standardization. As reflected in numerous studies as well as our experience serving helpline callers, many people struggle to select among several MA plans and multiple, complex plan variables. A 2011 *Health Affairs* study attributes some degree of beneficiary inertia with having too many plans from which to choose. The authors write, "Our study suggests that the Medicare Advantage program presents an overabundance of choices for elderly beneficiaries, posing a level of complexity far beyond that experienced by the nonelderly." The findings also show that difficulty selecting among MA plans and Original Medicare is more pronounced among older adults with low cognitive function, such as those in the early stages of dementia.[20]

To encourage efficient plan selection, distinctions among plans must be made more meaningful. We strongly support CMS' ongoing efforts to eliminate plans too alike other plans offered by the same insurer, and we encourage the agency to continue in this manner. At the same time, CMS should consider standardizing MA benefit packages, like the rubric required for supplemental Medigap plans (i.e., Plan A, Plan B, Plan C), to encourage "apples-to-apples" comparisons among plan options.[21]

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[19] Medicare Rights Center & Partner Organizations, "Letter to Andy Slavitt, CMS Acting Administrator" (September 2016), *available at* http://medicarerights.org/pdf/cms-letter-seamless-conversion-093016.pdf.

[20] J. Michael McWilliams, Christopher C. Afendulis, Thomas G. McGuire & Bruce E. Landon, "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking," *Health Affairs* 30:9 (September 2011), *available at* http://content.healthaffairs.org/content/30/9/1786.long.

[21] Ellen O'Brian & Jack Hoadley, "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice," Commonwealth Fund, (April 2008), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue Brief/2008/Apr/Medicare Advantage_Options for Standardizing Benefits and Information to Improve Consumer Choice/OBrien_Medicare_Advantage_options_1117_ib pdf.pdf; Paul Precht, David Lipschutz & Bonnie Burns, "Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans,"California Health Advocates & Medicare Rights Center, (September 2007), *available at* https://www.medicarerights.org/pdf/Informed_Choice.pdf.

MAINTAIN AND STRENGTHEN OVERSIGHT:

As noted in the RFI, the "MA and Part D programs have been successful in allowing for innovative approaches for providing Medicare and Part D benefits to millions of Americans." We strongly believe that carefully constructed regulations, ongoing monitoring and evaluation, and a reliance on transparent processes to guide any proposed changes to administrative policies are pivotal to this success.

We urge CMS to continue its robust oversight and management of the MA and Part D markets through multiple means, including the star ratings program, audit and enforcement procedures, and open and ongoing dialogue with stakeholders who represent diverse interests. Each of these tools plays a critical role in ensuring not only that MA and Part D plans are optimally serving their enrollees but also that taxpayer dollars are well spent. Towards this end, we encourage CMS to consider the following:

Enhance audit capacity and increase transparency on enforcement actions. We encourage CMS to revisit the agency's prior proposal to increase audit and inspection authority. In a 2015 proposed rule, CMS details the criteria by which it determines which MA and Part D plan sponsors are audited each year and acknowledges that limited resources allow the agency to perform annual audits on only 10% of plan sponsors—30 of 300. CMS previously proposed but chose not to finalize a rule requiring plan sponsors to hire independent auditors. Given persistently poor audit results, namely involving appeals and grievances, we ask CMS to revisit this proposal.[22]

Further, we greatly appreciate our ongoing dialogue with CMS and other consumer advocates on how to make enforcement actions, including intermediate sanctions and civil money penalties, more transparent. We are grateful for CMS' commitment to enhancing content on plan websites to reflect intermediate sanctions and for the additional information on common deficiencies recently incorporated in the agency's public report on audit findings.[23] Going further, we encourage CMS to prioritize the dissemination of public information on audit findings and resulting enforcement actions. In addition, we continue to strongly support CMS' pilot of additional audit modules on Medication Therapy Management (MTM) and the separate and more comprehensive audits of provider network adequacy and provider directories. We continue to hear directly from beneficiaries on both issues.

Continue to minimize inappropriate billing of Qualified Medicare Beneficiaries (QMB). We appreciate ongoing efforts by CMS to lessen illegal billing of QMB participants—who are among the lowest-income Medicare beneficiaries—by their health care providers. By law, people with QMB are appropriately shielded from Medicare Part A and Part B cost-sharing. Inappropriate billing risks the financial stability of these individuals, even causing some to be pursued by debt collectors.[24] We urge CMS to continue and expand on existing efforts, which include working with MA plans to ensure their network providers are educated and compliant.[25]

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[22] Centers for Medicare & Medicaid Services, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs: 6. Changes to Audit and Inspection Authority (§ 422.503(D)(2) and § 423.504(D)(2))" (January 10, 2014), *available at* https://www.federalregister.gov/d/2013-31497/p-450.

[23] Centers for Medicare & Medicaid Services, "2015 Part C and Part D Program Audit and Enforcement Report" (September 6, 2016), *available at* https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2015_C_and_D_Program_Audit_and_Enforcement-Report.pdf.

[24] Centers for Medicare & Medicaid Services, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)" (July 2015), *available at* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

[25] *See*, Centers for Medicare & Medicaid Services, "Reducing Inappropriate Billing of Qualified Medicare Beneficiaries" (December 2016), *available at* http://nhelp.org/conf2016/uploads/presenters/28_MMCO%20Inappropriate%20QMB%20Billing.pdf.

Establish strong beneficiary protections in the Part D lock-in program. Consistent with our written comments in December 2016 on the development of proposed rules to implement Section 704 of the Comprehensive Addiction and Recovery Act of 2016, we encourage CMS to develop regulations to implement that law in the way that is most protective of beneficiary access to needed medications.[26] Specifically, we encourage CMS to exempt people with certain diagnoses from the lock-in provisions; to develop beneficiary-friendly educational materials using the techniques described above; to provide for beneficiary preference in pharmacy designation; and to auto-escalate related appeals to the Independent Review Entity.

Further align Star Ratings and enforcement actions. As reflected in past comments, we continue to support CMS' work to thoroughly evaluate how audits, civil money penalties, and sanctions impact Star Ratings.[27] This work is important, as any disconnect between audit scores and the Star Ratings system can be a source of confusion for people with Medicare and professionals seeking to evaluate and compare plan quality.

We continue to strongly urge CMS to ensure that the Star Rating system does not camouflage or minimize plan behaviors that put Medicare enrollees at risk. When CMS determines that a plan's conduct poses a serious threat to the health and safety of beneficiaries, CMS should accurately signal this assessment through Star Ratings, providing beneficiaries with a clear tool that helps them fully evaluate and compare health plans. Of particular concern is the repeated finding of the same serious deficiencies in audit scores while Star Ratings continue to rise. To address this imbalance, it is critically important that Star Ratings incorporate audit measures and reflect audit results in meaningful ways, while CMS continues to impose significant sanctions and penalties when serious deficiencies are identified.

We remain skeptical that the finalization of CMS' recent proposal to adjust the Beneficiary Access and Plan Performance (BAPP) measure achieves the level of alignment needed among Star Ratings scores and audit results to convey a clear and consistent message to beneficiaries about plan performance.[28] For health plans placed under intermediate sanctions, we continue to recommend that CMS reconsider more significantly weighting the BAPP measure and/or adjusting the overall and summary Star Ratings by at least one star. Further, we continue to urge the use of a low-performing icon or other prominently displayed signal(s) of poor performance for sanctioned plans—regardless of their Star Ratings score.

SIMPLIFY PLAN-LEVEL APPEALS PROCESSES:

Year after year, the most common trend presented on the Medicare Rights national helpline involves a caller denied a health care service or prescription drug, most frequently by an MA or Part D plan. In 2015, more than one third (39%) of Medicare Rights' helpline callers expressed difficulty managing coverage denials and appeals. Among MA plans, the most frequent calls involved denials for physician services, many times related to out-of-network care. In Part D, most of our clients reported leaving the pharmacy without a prescribed medication and almost no callers report or recall receiving the required notice outlining their rights.[29]

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[26] Medicare Rights Center, "Re: Implementation of Section 704 of the Comprehensive Addiction and Recovery Act of 2016" (December 1, 2016).

[27] Medicare Rights Center, "Re: Enhancements to the Star Ratings for 2018 and Beyond" (November 2016), *available at* https://www.medicarerights.org/pdf/112916-comments-enhancements-star-ratings-2018.pdf.

[28] Centers for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information" (April 3, 2017), *available at* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf.

[29] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2015 Call Data from the Medicare Rights Center's National Helpline" (2017), *available at* https://www.medicarerights.org/pdf/2015-helpline-trends-report.pdf.

While limited public data is available on how well MA and Part D plans manage appeals, audit data made available by CMS suggests room for improvement. The top five deficiencies uncovered through the agency's audits of MA and Part D plans have remained consistent since 2011 and a significant share of these involve the management of denials and appeals. For example, in 2015, 68.1% of audited Part D sponsors issued denial letters to beneficiaries that either failed to include an adequate rationale or contained incorrect information. Also in 2015, 47.3% of audited MA organizations were shown to have inappropriately denied coverage to beneficiaries or payments to health care providers for services rendered. [30]

CMS has made notable attempts to help MA and Part D plans improve in these areas, such as through best practices memos and job aides. Nevertheless, persistent challenges remain—as reflected in audit scores and through our helpline experience. As such, we recommend the following:

Streamline Part D appeals. The appeals process is an essential safety valve, allowing access to prescription medications that are not on the plan's formulary, or are subject to high cost-sharing, when formulary or lower cost alternatives are not appropriate for a beneficiary's unique medical needs. To ensure that beneficiaries can successfully navigate the appeals process, we continue to strongly encourage CMS to improve information at the Point of Sale (POS) and to streamline the appeals process.

We believe that access to information about the reason for a plan denial—provided at the pharmacy counter—will both eliminate significant beneficiary confusion and limit delays in accessing needed medications. Findings by Medicare Payment Advisory Commission (MedPAC) confirm that many beneficiaries are unaware of their right to appeal prescription denials and do not know how to go about initiating the appeals process.[31] Armed with information about why a prescription drug was refused at the pharmacy counter, Part D enrollees and their providers will be better equipped to determine the best course of action for the beneficiary's health.

Along these same lines, we support allowing the pharmacy counter refusal to serve as the coverage determination itself. This proposal serves the dual purpose of removing burdensome steps for beneficiaries and their prescribers, first, by explicitly stating why the drug is not covered and, second, by expediting the appeals process for those who need it. These recommendations represent long-term solutions, as pursuing either of these proposals will require the National Council for Prescription Drug Programs to update electronic transaction standards under the Health Insurance Portability and Accountability Act's and the Affordable Care Act's administrative simplification provisions.[32] Nevertheless, we encourage CMS to recognize these options as viable and worthwhile pursuits.

At the same time, we continue to support efforts by CMS to explore opportunities to help beneficiaries secure access to needed medications absent coverage determination requests and appeals. For example, we suggest that CMS work with plans and providers to ensure that prescribers have access to their patient's plan's formularies at the Point of Care (POC) through e-prescribing practices. Ensuring that prescribers know which medications are on the plan formulary, and which are available at lower cost-sharing levels at the time they write the prescription, can avoid denials, appeals, and delays in access to needed care.

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[30] Centers for Medicare & Medicaid Services, "2015 Part C and Part D Program Audit and Enforcement Report" (September 6, 2016), *available at* https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2015_C_and_D_Program_Audit_and_Enforcement-Report.pdf.

[31] Presentation by Sokolovsky, L., Suzuki, S. and L. Metayer, "Part D exceptions and appeals" (September 2013), available at: http://www.medpac.gov/transcripts/part d exceptions & appeals.pdf; MedPAC, "Report to the Congress: Medicare Payment Policy, Chapter 14: Status Report on Part D" (March 2014; pgs. 368-369), available at: http://www.medpac.gov/docs/default-source/reports/mar14_ch14.pdf?sfvrsn=0

[32] ACA § 1104

CMS should test models for improving both POC and POS information in order to improve prescription drug adherence and health status by reducing the number of prescriptions sent to the pharmacy that are not aligned with an individual's Part D benefits. We also remain strongly supportive of commitments made by CMS in 2016 to strengthen beneficiary denial notices and to establish a data tracking system to monitor each stage of the Part D appeals process. We encourage this administration to continue to move forward with these initiatives.

Remove restrictions on Part D tiering exceptions. Tiering exceptions are currently not allowed for medications on the specialty tier—despite the fact these are among the highest cost medications, making them unaffordable for many beneficiaries with fixed incomes and limited resources. Medicare Rights continues to urge CMS to allow tiering exceptions for prescription drugs placed on a Part D plan's specialty tier, both as a matter of fairness and to promote affordable access to high-cost medications. Alternatively, we recommend that CMS consider limited cases where these exceptions would benefit a notable share of beneficiaries or establish another mechanism for cost-sharing relief among Part D enrollees unable to afford specialty tier medications, namely for those ineligible for the Low-Income Subsidy (LIS)/Extra Help.

We urge CMS to move swiftly to complete the agency's analysis announced in the Final 2017 Rate Notice and Call Letter on the effects of allowing tiering exceptions for specialty tier medications.[33] We continue to believe further study is needed to determine whether the longstanding prohibition on tiering exceptions for specialty tier medications is warranted. Particularly if any such analysis were to reveal that allowing tiering exceptions would have a minimal effect on plan costs, then we would hope this policy would be revisited.

Improve notice and education on tiering exceptions, especially at the Point of Sale (POS). We also encourage CMS to enhance beneficiary notice about tiering exceptions at the POS. We appreciate that CMS currently requires Part D plans and pharmacies to disseminate a standard notice at the POS for circumstances involving prescription drug denials or high cost-sharing.[34] As part of our standard counseling procedures, Medicare Rights asks all clients who are unable to fill a prescription about their receipt of this required notification. Year after year, the overwhelming majority of helpline callers report that they never received this notice.

As a first step, CMS should enhance oversight and enforcement of this notice requirement to ensure that Part D enrollees unable to afford needed prescription drugs are informed at the POS about tiering exceptions. Additionally, CMS should consider creating notification tailored to the tiering exception process and its unique rules, as opposed to disseminating a general notice that captures processes involving denials and utilization controls as well as tiering requests.

CMS should also create a targeted denial notice for tiering exceptions. We appreciate CMS' existing requirements that plans provide a standardized Part D denial notice, and we thank CMS for incorporating suggestions from Medicare Rights in its recent updates to this notice.[35] Still, we continue to believe these notices would be significantly improved if they were targeted to specific circumstances. We urge CMS to develop clearer and more useful denial notices that are tailored to tiering exceptions or the basis for a denial, as opposed to relying on the current catch-all notification.

[33] Final 2017 Rate Notice and Call Letter, p. 203.
[34] *See* "Medicare Prescription Drug Coverage and Your Rights" (Form CMS-10147), available at https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html.
[35] *See* "Notice of Denial of Medicare Prescription Drug Coverage" (Form CMS 10146), available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10146.pdf.

Finally, CMS should provide clearer information through 1-800-MEDICARE about the tiering exceptions process and how beneficiaries may engage in it if necessary. CMS should also report data—particularly at the plan level—related to the tiering exceptions process, such as the volume of requests, approval and denial rates, and reasons for approval or denial. This will help Part D plan sponsors, pharmacies, health care providers, and beneficiary advocates better understand the process and identify additional areas for potential improvement.

Enhance beneficiary supports and notice in MA denials and appeals. As outlined in a prior October 2014 report, we believe the following improvements to the MA appeals process—focused on the plan-level stages of appeal—could significantly ease beneficiary burden, and we encourage CMS to adopt policies that minimize enrollee confusion and any associated delays in accessing needed treatment following a denial by an MA plan[36]:

- **Streamline notice language and supply additional background material:** All too often, we come across denial notices that lack sufficient information on why a particular service is denied and/or are written in language that is extremely difficult for the average consumer to decipher. CMS should work with MA plans to simplify notice language and clarify what's required to make the case for medical necessity through an appeal.

  As an example, CMS could require MA plans to send copies of all materials used to arrive at a denial decision to the beneficiary, to the health care provider, and to the Independent Review Entity (IRE) evaluating the appeal. These materials should include both plain language reasons for the denial and cited excerpts from internal plan or CMS rules relied upon in the determination. All relevant rules, including those that might weigh in favor of coverage, should be included in the appeals materials. For example, if a service is denied because the provider was not in the network, the CMS rules describing under which circumstances out-of-network care must be covered, like for emergency services, should be included.

- **Enhance education and access to independent sources of support:** CMS should expand the ability of currently existing beneficiary resources, like SHIPs, to represent people in appeals. Additionally, the agency should make strides to improve consumer education, both through CMS and plans themselves, on how MA plans work, particularly with respect to coverage and access rules.

- **Continue rigorous monitoring and enforcement:** CMS should retain the audit modules and enforcement actions that are specific to the management of MA organizations' management of coverage and appeals processes to ensure accurate information and efficient assistance. In particular, CMS should enforce strict compliance with notice rules and requirements to effectuate timely decisions, holding MA enrollees harmless when a plan fails to meet the standards.

ENGAGE PATIENTS AND ADVOCATES IN INNOVATION:

Through the Centers for Medicare & Medicaid Innovation (CMMI), 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 MTM model.[37] Should the agency explore additional innovation options involving MA and

[36] Medicare Rights Center, "Medicare Snapshot: Stories from the Helpline, Managing Medicare Advantage Denials of Coverage and Appeals" (October 2014), *available at* https://www.medicarerights.org/pdf/medicare-snapshot-101614.pdf.

[37] Center for Medicare & Medicaid Innovation, "Request for Information on Health Plan Innovation Initiatives at CMS" (2014), *available at* https://innovation.cms.gov/files/x/hpi-rfi.pdf; Medicare Rights Center, "Re: Request for Information on Health Plan Innovation Initiatives at CMS" (November 3, 2014), *available at* http://www.medicarerights.org/pdf/110314-health-plan-innovations-rfi.pdf; Center for Medicare & Medicaid Innovation, "Medicare Advantage Value-Based Insurance Design Model" (last visited April 24, 2017), *available at*

Part D plans, we urge CMS to create mechanisms to ensure that people with Medicare and their advocates are fully involved in the development, implementation, and evaluation of these models. Towards this end, we strongly encourage the agency to:

- 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 supports via 1-800-MEDICARE and SHIPs; and
- Carry out beneficiary testing and readability reviews of patient-facing content for each model.

Create the Alternative Payment Model (APM) Ombudsman. In addition, as expressed in our recent comments on proposed rule delaying the effective date of the "Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model," we strongly 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 and supports.[38]

We applaud the creation of this APM Ombudsman program and urge CMS to move forward with urgency. 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 welcome a dialogue with CMS on how the agency plans to staff the APM Ombudsman office and other key questions about its infrastructure and ongoing engagement with outside stakeholders, like the Medicare Rights Center and other advocates.

Test value-based pricing initiatives to address rising prescription drug costs. Sky-high and ultimately unaffordable prescription drugs are among the most persistent and intractable problems we hear on the Medicare Rights national helpline, whether covered under Medicare Part B or Part D. We are heartened by initiatives in the private sector—such as indications-based pricing, outcomes-based risk-sharing agreements, and lowered cost-sharing for high-value medications—intended to tie reimbursement and/or cost-sharing to evidence on clinical-effectiveness. Medicare Rights encourages the CMS to consider testing these concepts in Part D, so long as any such testing is designed with robust consumer and patient input, incorporates adequate beneficiary protections, and ensures that all data, metrics, and outcomes are made fully transparent.

Retain consumer protections and enhance transparency in the MA V-BID model. As currently constructed, Medicare Rights continues to support the MA V-BID model. In particular, we appreciate that the model reflects CMS' careful consideration of many important beneficiary protections. In particular, we continue to support strong and clear parameters for program design, including: a transparent process for identifying high-value services and developing conditions of participation; permitting only cost-sharing reductions; limiting or prohibiting advertising and other pre-enrollment marketing of cost-sharing adjustments; opt-in beneficiary selection; and standardized

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https://innovation.cms.gov/initiatives/vbid/; Center for Medicare & Medicaid Innovation, "Part D Enhanced Medication Therapy Management Model" (last visited April 24, 2017), *available at* https://innovation.cms.gov/initiatives/enhancedmtm/.

[38] Medicare Rights Center, "RE: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date" (April 19, 2017).

notification for participating MA enrollees.[39] These essential elements of the program must be maintained, particularly in light of Congressional proposals to expand the model nationwide.[40]

We continue to encourage CMS to make the criteria and evidence-base used by participating health plans to designate particular services, prescription drugs, or health care providers as "high-value" publicly available, in addition to any wellness or disease management protocol(s) required of V-BID participants. Enhanced transparency along these lines will help ensure lessons learned from the MA V-BID model can be more broadly applied, such as in Traditional Medicare or the commercial market.

We also urge CMS to closely monitor beneficiary access to "high-value" health care providers in the MA V-BID model, so as not to unfairly limit access to lowered cost-sharing for such providers. Finally, we welcome a dialogue with CMS about early lessons learned from the demonstration, particularly with respect to beneficiary education and notices. We continue to believe CMS and participating health plans must be vigilant to ensure MA enrollees fully grasp the V-BID concept and how to access high quality care through the program.[41]

Research supplemental benefits across MA plans. We support CMS' continued evaluation of supplemental benefits packages to ensure that such packages are non-discriminatory and provide value to MA enrollees. Going further, we encourage CMS to review the range and type of supplemental benefits currently offered by MA plans nationwide and to make any such analysis publicly available.

We believe this type of analysis will be particularly valuable should CMS opt to test making additional or targeted supplemental benefits available through a CMMI demonstration program or otherwise. In addition to the expansion of the MA V-BID program, recent Congressional proposals would grant further flexibility to allow MA plans to provide non-health related services and supports as supplemental benefits for enrollees with chronic conditions.[42]

With appropriate oversight and monitoring, we believe this added flexibility could prove valuable, but there is little public information on what MA plans currently offer.[43] The current list of permissible optional supplemental benefits is fairly extensive, and evidence of whether the provision of such benefits improves care or lowers costs is needed to further legislative and administrative policy proposals on extending supplemental benefits to better manage chronic illness, address social determinants of health, or otherwise.[44]

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[39] *See* Medicare Rights Center, "Re: Request for Information on Health Plan Innovation Initiatives at CMS" (November 3, 2014), *available at* http://www.medicarerights.org/pdf/110314-health-plan-innovations-rfi.pdf.

[40] *See, e.g.*, Senate Finance Committee, "The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016" (October 27, 2016), *available at* https://www.finance.senate.gov/imo/media/doc/Chronic%20Care%20Section%20By%20Section.pdf.

[41] Medicare Rights Center, "RE: Medicare Advantage Value-Based Insurance Design (VBID) Model" (September 15, 2015), *available at* http://medicarerights.org/pdf/091515-ma-vbid-comments.pdf.

[42] *See, e.g.*, Senate Finance Committee, "The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016" (October 27, 2016), *available at* https://www.finance.senate.gov/imo/media/doc/Chronic%20Care%20Section%20By%20Section.pdf.

[43] *See, e.g.*, Senate Committee on Finance, "Bipartisan Chronic Care Working Group Policy Options Document" (December 2015), *available at* https://www.finance.senate.gov/imo/media/doc/CCWG%20Policy%20Options%20Paper1.pdf; McGrath, M.K. & Thorpe, K., "The Need For Additional Flexibility In Medicare Advantage" (August 29, 2016), available at http://healthaffairs.org/blog/2016/08/29/the-need-for-additional-flexibility-in-medicare-advantage/; Pope, C., " Enhancing Medicare Advantage, Lowering Costs for Seniors" (October 2015), available at https://morningconsult.com/opinions/enhancing-medicare-advantage-lowering-costs-for-seniors/.

[44] Medicare Managed Care Manual, "Chapter 4 - Benefits and Beneficiary Protections," Rev. 121 (April 2016), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf.

Approach added flexibility with care. In addition, it is important to note that any additional flexibilities granted to MA or Part D plans, namely any that allow plans to alter or target benefits, will likely add complexity to what is already an exceedingly complex program. As it stands, people with Medicare must evaluate MA and Part D plans based on monthly premiums, cost-sharing requirements and benefit tiering, covered services and prescription drugs, provider and pharmacy networks, and utilization controls and restrictions. And, as noted above, research consistently demonstrates that beneficiaries struggle to navigate and maximize their MA and Part D benefits—due in no small part to this complexity.

Given this, it is critically important that CMS match any new complexities in the MA and Part D programs with resources to educate people with Medicare about new variables that impact their coverage and care and to support them in their decision-making. Further, CMS should remain committed to strong monitoring and oversight of the MA program to guard against any discriminatory benefit designs, which are intended to discourage sicker and frailer beneficiaries from enrolling in particular health plans.

ACHIEVE PAYMENT ACCURACY IN MEDICARE ADVANTAGE:

The Medicare Rights Center's position on MA payment is simple—we believe that Medicare should pay a fair price for quality service. By the year 2030, there will be 70 million people in Medicare, and a burgeoning aging population will put new cost pressures on the program. As such, we believe it is in the best interest of both taxpayers and people with Medicare to fairly and efficiently reimburse for care provided by MA plans. Indeed, the purpose of offering MA options is to achieve better quality and lower costs through competition and innovation.

We also believe that any changes to MA payment rates must be transparent, predictable, and gradual to allow health plans to find operational and other efficiencies so rate cuts do not become benefit cuts or premium hikes for their enrollees. We aim to be pragmatic in our approach to MA payment changes, so as not to limit access to some of the real benefits that MA plans can provide.

Bearing these principles in mind, we continue to encourage CMS to more assertively address inappropriately inflated MA payments resulting from "upcoding" practices, such as by revisiting the agency's prior proposal to exclude in-home health assessments from the risk score; to continue with the agency's transition to the use of encounter data to establish MA risk scores; and to ensure bidding and payment for Employer Group Waiver Plans (EGWPs) is reflective those plans' true costs.