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March 6, 2020

VIA ELECTRONIC SUBMISSION

Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies–Part II

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the **Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies–Part II** (Notice). 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. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

Attachment II. Changes in the Part C Payment Methodology for CY 2020

Section A. MA Benchmark, Quality Bonus Payments and Rebate: We support the payment methodologies outlined in this section and we continue to observe that people with Medicare have ample choice and benefit from continued stability in the MA plan landscape. We urge CMS to continue to closely monitor the MA market to ensure that plans are optimally serving people with Medicare and that payments to these plans remain appropriate.

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Section F. MA Employer Group Waiver Plans: For 2021, CMS will continue to use the payment methodology as finalized in the 2020 Rate Announcement that includes waived bidding requirements alternate payment as outlined in the Final 2017 Rate Notice and Call Letter.[1] This policy is intended to reduce administrative burdens on employer plans and to more accurately capture EGWP costs by eliminating incentives to submit bids that are higher than projected costs. According to a 2014 MedPAC report, average Medicare payments to EGWPs were 106% of Traditional Medicare costs for comparable beneficiaries.[2] Further, EGWPs tend to have healthier, lower-cost enrollees than other MA plans and face lower administrative costs related to enrollment and marketing.

As we stated in our comments on the 2020 Advance Notice,[3] Medicare Rights generally supports this approach. In addition, we continue to support CMS's policy of permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment.

Attachment IV. Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2021

Section A. Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

Annual Percentage Increase for Out-of-Pocket Threshold: **Part D Out-of-Pocket (OOP) "Cliff":** The Part D OOP threshold has increased significantly—by over $1,000 from 2019 to 2020. The phenomenon is often referred to as the "OOP cliff." We are very concerned about the impact on beneficiaries with significant chronic health needs as they may linger in the coverage gap phase longer. Given the OOP costs facing the affected beneficiaries, we are concerned this could drive therapy abandonment. With this sharp escalation of the OOP threshold now a reality, we hope that CMS can work with Congress to determine an appropriate solution.

Attachment V. Updates for Part C and D Star Ratings

Measure Updates for 2021 Star Ratings

2021 Star Ratings Program and the Categorical Adjustment Index

[1] Final 2017 Rate Notice and Call Letter, pp. 27-29.

[2] MedPAC, "Report to The Congress: Medicare Payment Policy" (March 2014), http://medpac.gov/documents/reports/mar14_entirereport.pdf.

[3] Medicare Rights Center, "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 Call Letter" (March 7, 2019), https://www.medicarerights.org/comments-2020-call-letter.

We continue to be concerned by CMS's policy of adjusting Star Ratings scores based on socioeconomic and disability status. This approach risks creating two or more standards for care quality. To combat this, CMS should not adjust quality measures until it is clear that disparities revealed by the measures are truly due to circumstances outside of the plan's control, rather than choices the plan has made. We continue to urge CMS to develop a plan and timeline for phasing out this adjustment.[4]

We oppose expanding quality measure stratification. Risk adjustment in payment, rather than in quality assessment, better addresses the increased challenges related to serving higher needs individuals and individuals at risk because of social determinants of health. We strongly urge CMS to avoid creating disparate expectations of plan performance that would allow higher quality scores for more poorly performing plans simply because they serve lower income individuals.

Changes to Existing Star Ratings and Display Measures

Transitions of Care: Transitions continue to be hazardous. We remain in support of efforts from CMS and the National Committee for Quality Assurance (NCQA) to better evaluate a plan's success at effectively transitioning care from a clinical setting to the home, including the development of this measure. Transitions increase the risk of complications and adverse events because they require coordination and communication between several parties.[5] Because of this vulnerability, sound and tested transitions of care measures are especially important.

Concurrent Use of Opioids and Benzodiazepines (COB), Use of Opioids at High Dosage in Persons Without Cancer (OHD), Use of Opioids from Multiple Providers in Persons Without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (Part D). We continue to encourage that this measure exclude individuals in palliative care or at end of life, not just those with cancer or sickle-cell disease or those in hospice. The situation of these individuals is equivalent to those in hospice and it is important that measures do not incentivize denying them appropriate and needed pain relief.

Potential New Measure Concepts

[4] *See* Medicare Rights Center, "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 Call Letter" (March 7, 2019), https://www.medicarerights.org/comments-2020-call-letter; *see also* Medicare Rights Center, "Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter," pp. 5-6 (March 2016), https://www.medicarerights.org/pdf/2017-call-letter-comments.pdf.

[5] Agency for Healthcare Research and Quality, "Chartbook on Care Coordination: Transitions of Care" (last accessed February 11, 2020), https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html.

Prior Authorizations (Part C). Medicare Rights supports the creation of measures for prior authorizations to support beneficiary access to necessary and reasonable care. As we know from our National Consumer Helpline, people with Medicare too often face extensive barriers to accessing their care because of burdensome, redundant, or too-frequent review. More must be done to ensure that the proper processes are in place to allow individuals to access the care they need. A similar measure should also be considered for Part D prior authorization or other utilization management tools.

Generic Utilization (Part D). Medicare Rights supports the use of generic medications generally, as they are often associated with reduced costs and greater affordability for people with Medicare. However, we urge CMS to be cautious in instituting incentives for Part D plans to restrict access to brand-name medications. We oppose measures that may result in additional or higher barriers for patients to receive the appropriate medication. In particular, we are concerned that incentivizing biosimilar medications will present a potentially serious risk to patient safety for those already stabilized on the reference product. Once consumers have found a medication that works for their condition, plans must be discouraged from interfering with their clinical choices.

Initial Opioid Prescribing (IOP) Measures (Part D). Medicare Rights urges any new opioid measure development to exclude palliative and end of life care as well as hospice to ensure people in those circumstances do not face barriers to accessing needed and appropriate pain relief.

Thank you again for the opportunity to comment on these proposals. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi

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President
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