AARP
Real Possibilities

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December 31, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via regulations.gov

RE: CMS-4185-P

Dear Administrator Verma:

AARP is pleased to submit the following comments on the Proposed Rule for the CY 2020 and 2021 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-For-Service, Medicare Prescription Drug Benefits, and PACE programs.

AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps empower people to choose how they live as they age, strengthens communities, and fights for the issues that matter most to families, such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

We are committed to ensuring older Americans have affordable access to high-quality, high-value health care. In particular, we have worked to improve access and quality in Medicare and Medicare Advantage, and to ensure the beneficiary's perspective is part of care delivery. We have long supported the use of telehealth to increase access to services and providers, to align Medicare and Medicaid to better coordinate care and simplify access to protections for particularly vulnerable elderly, and to continue to support high quality health care.

Telehealth

AARP supports the improvements in access to healthcare services and providers that could come about from expanding use of telehealth services. Medicare enrollees in rural areas, other underserved areas, and those who are home-bound can especially benefit from expanding access to telehealth providers and services.

As such, we have generally supported the Bipartisan Budget Act of 2018 provisions allowing Medicare Advantage plans to provide additional telehealth benefits as part of its basic benefits. To the extent that these changes encourage broader availability of telehealth, we support changes to improve access to health care for Medicare Advantage enrollees.

In implementing these provisions, we encourage CMS to ensure that telehealth does not become a substitute for in-person health services nor used as a tool to curtail necessary offices visits. Accordingly, we urge CMS to finalize its proposal to require that an enrollee must be given a choice of receiving a Part B service as an additional telehealth benefit or in person. Further, to ensure that enrollees are well-informed about the providers and the telehealth services that are available to them, we support CMS' proposal that each enrollee be advised about their choice of receiving a Part B service as an additional telehealth benefit or in-person by including that information in the plan's Evidence of Coverage.

AARP also supports CMS' proposed requirement that a plan's provider directory distinguish between providers offering services for additional telehealth benefits and in-person visits from those offering services exclusively for additional telehealth benefits. As CMS' own Online Provider Directory Review Report[1] has indicated, however, online provider directories have very high rates of inaccuracies and deficiencies. Vulnerable enrollees can be put at great disadvantage when enrolling in a plan based on the availability of certain providers only to later learn that the directory was in error and their providers or service locations are not covered. We urge CMS to increase its oversight of provider directories, use all available tools to ensure that consumers have real-time access to accurate provider directories, and take action against plans with repeated deficiencies.

While we are pleased with the progress in access to telehealth services for beneficiaries enrolled in Medicare Advantage plans, we strongly urge CMS to work to ensure that similar improvements in access to telehealth services is provided to beneficiaries enrolled in fee-for-service Medicare. It is disconcerting that traditional Medicare has not fully benefited from the same innovative services that could help patients and providers alike. Telehealth can improve access to care, especially for rural beneficiaries and those who cannot travel to a provider's office of facility. We urge CMS to use its authority to explore and implement new ways that traditional Medicare could benefit from innovative services.

[1] Centers for Medicare and Medicaid Services, Online Provider Directory Review Report 2017

Dual SNP Alignment and Unified Grievance and Appeals Proposals

Both Congress and the agency have recognized the complications that dual eligible beneficiaries face navigating the Medicare and Medicaid programs and access to needed services. The two programs provide separate or at times overlapping benefits as well as separate administrative processes. This fragmentation makes care coordination unnecessarily complicated resulting in ineffective care (e.g., preventable hospitalizations) as well as poorer patient outcomes and patient experiences. CMS notes that about 2.3 million dually eligible beneficiaries are enrolled in Dual Eligible Special Needs Plans (D-SNPs).

AARP supported the Bipartisan Budget Act of 2018 policies to better integrate Medicare and Medicaid program benefits for dual eligible beneficiaries enrolled in D-SNPs and to unify the grievance and appeals procedures for those enrollees. However, the proposed regulatory implementation of the unified system for grievances and appeals falls far short of the goals of the legislation.

AARP is extremely concerned that the proposed rule's unified grievance and appeals process would only impact a very small number of dual eligible beneficiaries enrolled in certain D-SNPs. By applying the requirement solely to Fully Integrated Dual Eligible (FIDE) SNPs and Highly Integrated Dual Eligible (HIDE) SNPs that have exclusively aligned enrollment, only 150,000 of the universe of 2.3 million dual eligible beneficiaries would have access to the unified system under the proposal.

AARP urges CMS to revise its proposals so that they apply to all dual eligible beneficiaries enrolled in D-SNPs, without regard to the specific type of D-SNP plan category. The agency has the authority to establish and impose plan terms and conditions on organizations contracting to provide these benefits to this patient population. Failure to do so will continue the same fragmented delivery of care for these individuals which will do little to address poor patient outcomes or inefficient delivery of care. The agency should take whatever steps necessary to reduce beneficiary confusion and to simplify access to needed services by streamlining the grievance and appeals system for beneficiaries enrolled in all D-SNPs.

Further, the proposed unified grievance and appeals system would not be available after plan-level determinations and reconsiderations, meaning that the same fragmentation that Congress sought to correct will apply for beneficiaries seeking to challenge plan decisions at the appeals level. Thus, dual eligible beneficiaries will first have to determine whether the benefit in question is a Medicare or Medicaid benefit and then file their appeal(s) with an Independent Review Entity for Medicare Advantage benefits or with a State Fair Hearing for Medicaid benefits; the beneficiary may also have to file appeals to both entities simultaneously or sequentially. We are concerned this will be burdensome for beneficiaries and will not serve as a true recourse.

AARP also urges CMS to extend the policy goal of unified grievance and appeal beyond plan-level decisions. We support provisions of the proposed rule that carry out statutory

requirements to select individual review process policies from the Medicare Advantage and Medicaid MCO grievance and appeals systems that are most favorable to the beneficiary. We also support use of the Medicaid continuation of benefits policies because they are more comprehensive. CMS should provide for the most robust application of the statutory requirement to continue benefits pending appeal. The agency should ensure that plans provide assistance to beneficiaries in meeting the Medicaid process requirements and conditions for continued coverage of benefits during appeals, including understanding the applicable requirements and meeting deadlines.

Finally, as D-SNP plans work to implement these requirements, CMS should identify best administrative practices and work to support plan sponsors as they comply with them. During initial harmonization efforts, there will undoubtedly be some administrative cost. However, that burden can be eased if plans are provided with clear examples and strategies to develop information systems that support harmonization efforts. CMS should also provide technical support to plans during the implementation process.

Star Ratings

AARP strongly supports the use of Star Ratings which provide helpful summary information to beneficiaries when choosing among Medicare Advantage and Medicare Part-D plans. AARP especially appreciates CMS' efforts to continually improve the Star Ratings system to become increasingly accurate in reflecting plan quality and enrollee experience. We strongly support the ongoing enhancements to the Star Ratings programs that signal CMS' expectation that to qualify for financial rewards, MA organizations must demonstrate high quality in the form of excellent patient outcomes and experiences.

Part D Drug Plan Sponsors' Access to Medicare Parts A and B Claims Data

AARP supports efforts to improve care coordination for Medicare FFS beneficiaries and believes that allowing stand-alone Part D plans (PDPs) to access Medicare Parts A and B claims data will help achieve this goal. Prior to the Bipartisan Budget Act of 2018, PDPs did not have access to claims data beyond the pharmacy transactions that they managed for their enrollees, making it difficult for them to determine whether enrollees' prescription drug regimens were appropriate. Giving PDPs access to Medicare Parts A and B claims data will help reduce this silo effect and promote appropriate medication use and improved health outcomes. However, AARP believes there must be clear and strong restrictions on the use of the claims data, including prohibiting its use in informing coverage determinations, conducting retroactive reviews, marketing or sharing data with other entities. We urge CMS to monitor Part D plan sponsor use of this data to ensure such restrictions are rigorously enforced.

Improving Clarity of the Expectations Timeframes for Part D Drugs

AARP is among a wide variety of stakeholders—including beneficiaries, prescribers, plan sponsors, MedPAC, and CMS—that has raised concerns about the Medicare Part D exceptions and appeals process. More specifically, AARP has urged CMS to improve the process to respond to concerns that it is too complicated and cumbersome for enrollees to successfully navigate. The Medicare Part D exceptions and appeals process should be transparent, easy-to-understand, and fair in order for it to function as a true recourse for enrollees.

CMS is proposing to limit the amount of time an exception request can be held in a pending status while the Part D plan sponsor attempts to obtain the prescribing physician's or other prescriber's supporting statement. Plan sponsors will now have 14 days to render a decision on an exception request. This proposal is intended to create more certainty in the timeframe applied to the exceptions process. CMS notes that this deadline could also incentivize more timely submission of supporting statements by prescribers.

If this approach is finalized, CMS should monitor its impact to ensure that the 14-day deadline does not accelerate the already growing number of denials and appeals under Medicare Part D. AARP also strongly urges CMS to monitor whether this change ultimately increases the length of time that enrollees must wait before they receive a final decision.

Finally, AARP strongly believes that CMS must be willing to regularly revisit and make changes to the exceptions and appeals process as necessary, as it is the best way to ensure adequate beneficiary access. A streamlined, transparent, and responsive process would help mitigate many of the legitimate access concerns that are raised in response to proposed changes to Medicare Part D.

Thank you for the opportunity to share our comments on the proposed rule. If you have any additional questions, feel free to contact me or contact Brendan Rose on our staff at brose@aarp.org.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director