



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

April 6, 2020

Administrator Seema Verma
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-4190-P

Dear Administrator Verma:

We, the co-chairs of the Consortium for Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule outlining policy and technical changes for the Medicare Advantage, Medicare Part D, and other programs. This letter primarily addresses Medicare Advantage (MA) and Part D plans.

The CCD is the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. This response to the Proposed Rule focuses on: regulation of dual-eligible special needs plan look-alikes, special supplemental benefits for the chronically ill, network adequacy requirements, the proposed Beneficiary Real Time Benefit Tool, and updates to the Health Outcome Survey and plan quality rating measures.

Dual-Eligible Special Needs Plan “Look-Alikes”

The Health Task Force greatly appreciates CMS' past and proposed regulatory action to curb the growth of Dual-Eligible Special Needs Plan (D-SNP) “look-alikes,” which foster confusion among beneficiaries and present real harm to integrated delivery systems and the care provided to dual-eligible beneficiaries, many of whom have significant disabilities or chronic conditions. We agree with CMS that the proliferation of look-alikes is a matter of significant concern for the Medicare and Medicaid programs, and if allowed to continue unchecked, these may seriously undermine the goals of developing D-SNPs in the first place.

We support the proposals in the rule to restrict D-SNPs and urge CMS to go further to promote integrated and coordinated care for dual-eligible beneficiaries. The Proposed Rule includes a provision that would prohibit CMS from entering into or renewing a contract for a look-alike in any state where there is a D-SNP or other plan exclusively consisting of dual-eligible enrollees. The contract requirements proposed by CMS are an important step, but we recommend that CMS ensure that these requirements apply to all states, including those that do not currently have D-SNPs or Medicare-Medicaid plans. The proposed exemption for the eight states currently without D-SNPs would potentially leave room for look-alikes to continue to proliferate and detract from existing efforts to coordinate care for dual-eligible beneficiaries, even if those efforts do not come in the form of a D-SNP. Additionally, we suggest that CMS lower the proposed threshold of dual-eligible enrollment (80% in the Proposed Rule) to 50%. This would ensure that look-alike plans would not be able to game the system and create look-alikes that fall just under the 80% threshold and would help ensure that more dual-eligible beneficiaries enroll in plans that are truly committed to the coordination of their care.

Look-Alike Crosswalk Proposal

The Proposed Rule includes a plan to transition or “crosswalk” dual-eligible beneficiaries who are currently enrolled in D-SNP look-alikes to another MA plan offered by the same organization “to minimize disruptions” as a result of the contract renewal prohibition for existing look-alikes. Beneficiaries who are transitioned to a new plan would receive an Annual Notice of Change describing any changes in the beneficiaries’ coverage and benefits regarding the transition. We support this notification and encourage CMS to expand the information in the ANOC to include a discussion of any providers, especially primary care providers and specialists, that the beneficiary has seen under the old plan who will not be in-network under the crosswalked (“receiving”) plan.

Relating to networks, we encourage CMS to set a standard requirement that the receiving plans must have at least network that significantly overlaps with the original look-alike plan. Beneficiaries who are crosswalked into a new plan should not face significant reductions in their provider network, and we recommend a 90% threshold to ensure that beneficiaries have a smooth transition. If the expected crosswalked plan will not meet this requirement for a given beneficiary, we encourage CMS to instead default that beneficiary into traditional Medicare. Additionally, as the crosswalks are being planned, the default option (assuming the 90% threshold is met) should be to transfer a beneficiary directly to a D-SNP plan, rather than any other MA plan offered by the organization.

Supplemental Benefits for Beneficiaries with Chronic Conditions

We appreciate CMS’ attention to implementing non-primarily health related “special supplemental benefits for the chronically ill” (SSBCI) under the Bipartisan Budget Act of 2018. Access to a broad range of non-primarily health related items and services, such as transportation for non-medical needs and home-delivered meals, is important for enabling MA enrollees to live as independently as possible and for as long as possible in their homes and communities.

These non-primarily health related supplemental benefits should be reasonably available to all beneficiaries who meet the definition of a “chronically ill enrollee.” The Task Force opposes any contemplated arbitrary limits on these supplemental benefits, such as dollar amounts or other limits. Such limits would restrict access to these items and services in direct contravention of congressional intent. Meanwhile, the Task Force supports CMS’ proposal to codify the ability of an MA plan to consider social determinants, such as financial need including food and housing insecurity, in determining non-primarily health related supplemental benefits for MA plan enrollees with chronic conditions, provided that such benefits must always be available in a nondiscriminatory manner.

We appreciate that CMS proposes to adopt a uniform definition for determining which chronic conditions meet the statutory standard and support the formation of a panel of clinical advisors to establish and update this list. Such a definition is important to ensure that benefits are provided consistently and reliably across MA plans and that MA plans do not inappropriately limit access to these benefits. We urge CMS to clarify that any “flexibility to continue to innovate” provided to plans only allows MA plans to address additional conditions or needs in their population that are not on the CMS-approved list, and not to determine that CMS-identified conditions do not meet a given plan’s internal criteria.

MA and Cost Plan Network Adequacy

In this rule, CMS is proposing to codify the standards and methodology used to evaluate network adequacy for MA plans. The adequacy of a plan’s provider network can impact the level of access to benefits for enrollees. For MA enrollees to benefit from appropriate rehabilitation, the Task Force believes that MA plans must adhere to patient-friendly network adequacy standards that provide ample access to the full complement of rehabilitation and habilitation service and device providers, professionals, and facilities that provide both primary and specialty care. These services should be provided based on the individual’s needs, prescribed in consultation with an appropriately credentialed clinician, and based on the assessment of an interdisciplinary rehabilitation team and resulting plan of care.

CMS is proposing to codify the list of provider and facility specialty types subject to network adequacy reviews. The facility specialty types proposed to be included do not include post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs). The Task Force urges CMS to include IRFs in the facility specialty types as part its network adequacy reviews. A wide range of rehabilitation provider types will help ensure that enrollees have access to the appropriate intensity and scope of needed rehabilitation services. For instance, too often enrollees across the country are diverted into nursing homes rather than IRFs because their health plans do not contract with a sufficient number of these providers. Too often, enrollees with brain injuries, spinal cord injuries, those who have suffered strokes, and others with a variety of complex but common conditions do not receive the intensive longer-term services they need because health plans do not contract with specialized brain treatment programs.

CMS is also proposing to set maximum time and distance standards for the providers and facility specialty types subject to network adequacy standards. Network adequacy standards should

ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under the plan and recognize that many people with disabilities lack transportation options.

Additionally, CMS is proposing to credit MA organizations 10% points towards the percentage of beneficiaries residing within time and distance standards for contracting with telehealth providers for certain specialties. The Task Force supports increased access to care through the use of telehealth, as long as it does not come at the expense of providing quality care to people with disabilities.

People with disabilities should have access to disability-specific specialists and services, in settings that are physically accessible, and with a choice of providers—primary, specialty, and subspecialty. The Task Force believes that the adequacy of a plan’s provider network dictates the level of access to benefits otherwise covered under the health plan. If a plan covers a benefit but limits the number of providers or specialists under that plan, coverage will be curtailed through a lack of access to providers with sufficient expertise to treat the patient. Additionally, network adequacy standards should ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under a plan. In light of these concerns, CMS must ensure robust network adequacy standards and these standards must be strongly enforced. It is essential that Americans have access to affordable and meaningful coverage of rehabilitative services and devices.

Beneficiary Real Time Benefit Tool

The Proposed Rule proposes to require Medicare Part D plan sponsors to implement a beneficiary-facing “Real Time Benefit Tool” (RTBT) that would “allow enrollees to view accurate, timely, and clinically appropriate” real-time formulary and benefit information. CMS proposes to require inclusion of cost-sharing information, formulary alternatives, and utilization management requirements within the information displayed in the RTBT. We support efforts to present beneficiaries with digestible, accurate information regarding their expected out-of-pocket costs, and encourage CMS to work with plan sponsors to develop tools that present this information in plain language so that beneficiaries can make informed decisions regarding their prescriptions.

Health Outcomes Survey Measures

The Proposed Rule includes substantive updates to measures in the Medicare Health Outcomes Survey (HOS), namely, the Improving or Maintaining Physical Health (PCS) and Improving or Maintaining Mental Health (MCS) measures. Additionally, CMS seeks comment on expanding these existing HOS measures to the under-65 Medicare population. We urge CMS to expand these HOS measures to include beneficiaries under the age of 65 years. While most Medicare beneficiaries are in the program after reaching age 65, a significant amount (more than 1 in 7, according to the Kaiser Family Foundation) are younger beneficiaries in the program due to significant disabilities or chronic conditions, including many who are dually eligible for Medicare and Medicaid. Medicare provides critical resources for these beneficiaries and the

metrics used to evaluate the program in the HOS should take into account the full population of Medicare beneficiaries.

Star Rating Enhancements

The Proposed Rule includes updates to the methodology and measures for the quality rating system for MA and Part D plans (“Star Ratings program”). We appreciate CMS’ proposal to increase the weight of patient experience/complaints and access measures, as these reflect key considerations for beneficiaries when evaluating and choosing a plan under these programs. The existing measures within these categories include important metrics such as ease of getting needed care, members’ ratings of quality of care, and more. We are also pleased that CMS will continue to measure plans on their responses to appeals, including whether MA plans make timely decisions about appeals (measure DMC16).

We encourage CMS to consider an additional measure for MA plans that would track what percentage of denied claims are elevated to review by an independent entity. The Reconsideration to an Independent Review Entity (IRE) stage is a critical step in ensuring that beneficiaries who have had claims denied are able to have a third-party, objective review of their appeal. When evaluating plans, beneficiaries should be able to understand if a given plan issues a large number of denials at redetermination that may indicate barriers to accessing care.

The Task Force also appreciates CMS’ attention to measures relevant to individuals with disabilities and chronic conditions through the past addition of measures examining care transitions from an inpatient setting to the home, as well as the proposed measure regarding follow-up care provided after an emergency department visit for patients with multiple chronic conditions. In future iterations of the Star Ratings system, we recommend that CMS add measures that examine access to rehabilitation in inpatient settings (IRFs), as well as outpatient or home-based settings. We also encourage CMS to adopt measures to assess MA plan compliance with the *Jimmo v. Sebelius* settlement, which explicitly rejects an “improvement standard” and clarifies coverage for skilled services provided to Medicare beneficiaries that improve, maintain, and prevent deterioration of function in skilled nursing facilities, home health agencies, and outpatient clinics.

Such measures should focus on both access to care and the functional outcomes of rehabilitation care in these post-acute care settings. The addition of such measures would be a key tool for determining the degree of access to rehabilitation care afforded to MA plan beneficiaries and holding MA plans accountable for ensuring access to these essential services.

We thank you for consideration of our comments. If you have any questions, please feel free to contact Peter Thomas at Peter.Thomas@PowersLaw.com or 202-466-6550.

Respectfully Submitted,

CCD Health Task Force Co-Chairs:

Peter Thomas
Brain Injury Association of America

Rachel Patterson
Epilepsy Foundation

Julie Ward
The Arc of the United States

David Machledt
National Health Law Program