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***Via Electronic Submission (www.regulations.gov)***

January 16, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-4182-P
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)**

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) proposed rule entitled *Medicare Program: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program*, 82 *Fed. Reg.* 56336 (November 28, 2017).

AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 149 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 167,000 full-time faculty members, 88,000 medical students, and 124,000 resident physicians. AAMC member hospitals are just 5 percent of all acute care hospitals but have 20 percent of all Medicare inpatient days.

The AAMC commends CMS for working to reduce burden on providers that serve beneficiaries enrolled in the Medicare Advantage (MA) program and the Prescription Drug Benefit program (Part D) while promoting program quality and accessibility, and improving beneficiary experience in revising the regulations for both MA and Part D. We urge CMS to ensure that

beneficiaries enrolled in MA and Part D plans continue to have access to providers and pharmacies with whom they have long-standing relationships. In an effort to decrease burdens associated with reporting requirements, CMS should work to align any new physician reporting requirements with information currently collected.

***Flexibility in the MA Uniformity Requirements***

CMS is updating its interpretation of sections 1852(d) and 1854(c) of the Social Security Act (the Act) that benefits offered by MA plans must be available and accessible to, and premiums must be uniform for, each beneficiary enrolled in the plan. CMS is now interpreting the MA regulations at 42 CFR §422.100(d) to mean that uniformity requirements are met even if MA Organizations (MAOs) reduce cost sharing for certain covered benefits; offer specific tailored supplemental benefits; and offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees are treated the same (82 *Fed.Reg* 56360).

Many academic medical centers and physician faculty practices serve a large volume of Medicare beneficiaries – many with multiple chronic conditions – and understand the complex medical needs these patients face. While we support CMS's efforts to better target the needs of beneficiaries, we agree that plans must be held accountable for ensuring "compliance with non-discrimination responsibilities and obligations" (p. 56360) to guarantee that all beneficiaries enrolled in these plans receive the care they need. Additional supplemental benefits for some beneficiaries should not be at the expense of others. Differential cost-sharing should be implemented only to the extent that it is evidence-based, and carefully targeted so as to encourage appropriate utilization to improve outcomes as they relate to specific disease conditions. Furthermore, supplemental benefits and services should be tailored with all beneficiaries in mind. When designing benefits, plans should take into account the needs of beneficiaries who require specialized care and have come to rely on academic medical centers to receive it, and should continue to have that care available to them with no additional cost-sharing

***Coordination of Enrollment and Disenrollment through MA Organizations and Effective Dates of Coverage and Change of Coverage***

CMS proposes to resume the use of a special type of enrollment where individuals who have been enrolled in non-Medicare health plans can be enrolled into an MA plan operated by the same organization when the individual first becomes eligible for Medicare. This enrollment process is often referred to as "seamless conversion" or "seamless continuation." In this proposal, CMS is also proposing to permit seamless default enrollments only for approved organizations that offer both Medicaid managed care plans and MA dual eligible special needs plans (D-SNPs), automatically enrolling members of the Medicaid plan into the affiliated D-SNP when they become eligible for Medicare (page 56365). Additionally, CMS is proposing some flexibility for MAOs that wish to offer seamless continuation of coverage to non-Medicare members, commercial, Medicaid or otherwise, who are gaining Medicare eligibility. This proposal would require affirmative elections for individuals not enrolled in a Medicaid managed

care plan, as part of a new "opt in" election process available to all MAOs for the MA enrollments of their commercial, Medicaid or other non-Medicare plan members (page 56367).

To encourage transparency, avoid confusing beneficiaries, and ensure that beneficiaries understand the coverage offered by their plans, the AAMC believes that it is preferable for beneficiaries to have to "opt in." CMS should require that plans provide sufficient information on the organization's MA plans in terms of provider networks, drug formularies, costs and benefit structures. CMS also should highlight any areas where the MA plans available differ from the individual's current non-Medicare coverage in order to ensure the MA plan meets the medical needs of the beneficiary.

***Updates to the MA and Part D Prescription Drug Plan (PDP) Quality Rating System***

In many previous comment letters and meetings, the AAMC has expressed concerns to CMS about the Hospital Star Ratings, including the need for better adjustments for socio-demographic status and other factors, and the worry that in its current form the ratings do not provide consumers with accurate information on which to base important health care decisions. The AAMC notes that CMS has previously finalized policy to adjust the MA Star Ratings metrics for plans that serve a disproportionate number of low-income beneficiaries. CMS has provided guidance about better transparency around which measures are appropriate, including what constitutes a valid measure; the process that must be in place for new measures to be added to star ratings; and the characteristics of measures that must go through rulemaking before being added to star ratings. The AAMC urges CMS to incorporate similar changes into the Hospital Star Ratings. AAMC member hospitals disproportionately treat disadvantaged and vulnerable patient populations.

- **Codifying the Existing Star Ratings System for MA and Part D Programs**

CMS proposes to codify the existing Star Ratings System for the MA and Part D programs and use *Federal Register* rulemaking to be used for the Star Rating System (page 56376). CMS intends to first announce changes through the annual Notice and Call Letter Process, and then propose and consider changes through formal rulemaking. The AAMC is encouraged to see increased transparency in the program.

***Reducing Provider Burden***

CMS is seeking comment on reducing provider burden as part of its broader exploration of ways to reduce burden on institutional providers of services, physicians and other health care practitioners (pages 56455-6).

The AAMC believes better alignment is needed between Star Ratings and Medicare physician quality programs, such as the Quality Payment Program (QPP). Oftentimes, the activities a physician is required to participate in to comply with requirements that earn an incentive for a plan do not align with QPP, meaning that they then need to participate in a separate set of activities in order to meet QPP requirements. When physicians are required to participate in

specific activities to comply with requirements that earn a plan an incentive, typically they are not compensated for that time and do not receive credit for it. This lack of alignment between adherence to plan requirements and quality payment program requirements leads to an increased administrative burden for physicians, and forces physicians to address competing priorities between the multiple sets of requirements. While increased quality measures can lead to better quality of care, it also leads to a significant burden shouldered most significantly by physicians, increasing the amount of time they spend on administrative tasks instead of with patients.

- **Physicians Experience Measures and Physician Action Requirements**

CMS requests stakeholder feedback on how well the existing star measures create meaningful quality improvement incentives and differentiate plans on quality. In particular, CMS is considering developing a survey tool for collecting standardized information on physicians' experiences with health and drug plans and their services, and including survey measures of physicians' experiences in the star measures, similar to current Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures of beneficiary experience with respect to health and drug plans (page 56377). We commend CMS on its plans to seek feedback from physicians on their experience with health and drug plans and the star measures and would welcome the opportunity to provide our input on a survey tool as it is developed.

- **Part D Tiering Exceptions**

Currently, a beneficiary enrolled in a Part D plan that is offering benefits for Part D drugs through the use of a tiered formulary may request an exception to the plan sponsor's tiered cost-sharing structure. Plan sponsors must have a process in place for making determinations on requests for exceptions, consistent with guidelines established by the Secretary. The current regulations permit enrollees under certain circumstances to obtain a drug in a higher cost-sharing tier at the more favorable (lower) cost- sharing (copayment or coinsurance) applicable to alternative drugs on a lower cost-sharing tier of the plan's formulary. The plan must provide this exception if the non-preferred drug is medically necessary based on the prescriber's supporting statement.

Drug utilization management tools such as tiering and prior authorization are often used to reduce utilization and spending on high-cost prescription drugs, often impose unnecessary administrative burdens on prescribers and access delays on patients. This is further complicated by the fact that many plan sponsors now utilize multi-level tiering as a way to manage high-cost prescription drugs. Requests for exceptions to tiering usually require prescribers to provide written rationale for the exception. Providers treating patients enrolled in a variety of Part D plans, each with their own formularies and utilization management requirements, require them to sift through a myriad of information in order to ensure patients receive the drugs that best treat their conditions. Similar to quality measure requirements, physicians receive no compensation for the administrative time required to address burdens plans often have in place to access these medications.

With the hurdles Part D prescription drug plans often have in place related to utilization management and tiering, it would significantly reduce the administrative burden placed on physicians if there was greater transparency on which medications require utilization

management tools. This increased transparency would also benefit patients seeking information about their care in addition to reducing burden on the practitioners who treat them.

- **Patient Risk Scores**

The methods used for calculating beneficiary risk scores impose a significant administrative burden on physicians because plans focus on optimizing payment through risk scores. As CMS increases monitoring and compliance activities related to beneficiary risk scores, they should closely evaluate the impact of these activities on physician documentation and other administrative activities. As has been mentioned in relation to Star Ratings, QPP reporting, and prior authorization processes, these activities take up significant administrative time for physicians, time that could be spent on patient care.

***Changes to the Medical Loss Ratio (MLR) Requirements***

CMS is proposing to remove the exclusion of fraud prevention activities from the current definition of quality improvement activities (QIA), thereby allowing fraud reduction activities – including fraud prevention, detection and recovery – to be considered quality improvement activities that count in the MLR numerator. CMS states in the proposed rule that limiting or excluding investments in fraud reduction "undermines the federal government's effort to combat fraud in the Medicare program" (p. 56457).

The MLR provision requires insurers to spend a specified percentage of total premiums on medical costs. Under the MLR requirement, MA and Part D plans are required to maintain a minimum MLR – the percentage of revenue spent on incurred claims and health care quality improvement activities – of 85 percent. The remaining 15 percent represents the maximum portion of premiums that can be put towards administrative costs and profits, combined.

The AAMC recognizes the importance of fraud prevention activities. However, quality improvement activities should not include costs that focus on improving the quality of the insurance plan itself or activities related to cost containment that benefit the insurance plan. We are concerned that the CMS proposal could artificially increase plans' MLRs, thus providing an inaccurate picture of the amount of premium dollars actually spent on medical costs. CMS states in the proposed rule that including fraud reduction activities within the QIA will "provide additional incentive to encourage MA organizations and Part D sponsors to develop innovative and more effective ways to detect and deter fraud" (p. 56457). QIAs must lead to measureable improvements in patient outcomes or patient safety. The MLR should include only those costs designed to improve health care quality by producing results that can be objectively measured and verified.

CMS is also proposing to simplify the reporting requirements for MA and Part D plans, requiring them to report only the final MLR percentage and any remittance due, instead of the requirement to report the build-up of the MLR amount, as currently required. The AAMC urges CMS not to finalize this proposal. MA and Part D plan sponsors should continue to submit to CMS clear reporting of all activities with related expenses to ensure MA and Part D plan sponsors accurately account for quality improvement activities and do not overstate these costs.

***Contract Consolidations***

CMS is proposing a new set of rules regarding the calculation of Star Ratings for consolidated contracts. CMS agrees that the practice of contract consolidation that moves beneficiaries from lower Star Rating contracts that do not receive a quality bonus payment (QBP) to higher Star Rating contracts that do receive a QBP is worrisome. This also increases the size of the QBPs that are made due to the large enrollment increase in the higher rated, surviving plan. CMS states that it is concerned that this practice masks low quality plans under higher rated surviving contracts and does not provide beneficiaries with accurate and reliable information for enrollment decisions. Instead, CMS proposes to assign Star Ratings "based on the enrollment-weighted mean of the measure scores of the surviving and consumed contract(s) so that the ratings reflect the performance of all contracts (surviving and consumed) involved in the consolidation" (p. 56380). CMS will use the enrollment-weighted means of the measure scores of the consumed and surviving contracts to calculate ratings for the first and second plan years following the contract consolidation.

The AAMC appreciates CMS's acknowledgement that the consolidation of low Star Rating contracts into higher Star Rating contracts is problematic. However, we believe that using enrollment-weighted means to assign Star Ratings will continue to favor consolidation into higher Star Rating contracts. Large contracts with higher Star Ratings will receive higher QBPs even though they may have some local area plans that perform poorly. Underperforming plans will be awarded an unfair advantage in some markets because of the higher Star Rating. Additionally, we believe consumers will receive inaccurate information about plans' performance within their area, particularly if the plan in their local area is not the higher rated plan. CMS must work to ensure that beneficiaries are given accurate, reliable information about local area plans so they are able to choose the plan that best meets their needs.

**CONCLUSION**

Thank you for the opportunity to comment on the Policy and Technical changes to the MA Program CY 2019 proposed rule and for your consideration of these comments. If you have any questions concerning these comments, please feel free to contact Mary Mullaney, Director, Hospital Payment Policies at mmullaney@aamc.org or 202.909.2084 or Gayle Lee, Director, Physician Payment Policy and Quality at galee@aamc.org or 202.741.6429.

Sincerely.

Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer

cc: Ivy Baer, AAMC