AMGA
Advancing High Performance Health

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Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS-4190-P

Dear Administrator Verma:

On behalf of AMGA, I appreciate the opportunity to comment on the "Calendar Year (CY) 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program; Medicare Prescription Drug Benefit Program (CMS-4190-P)."

Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, patient-centered medical care.

Medicare Advantage (MA), with its supplemental benefits and cap on out-of-pocket costs, provides an attractive benefit package for beneficiaries and offers providers flexibilities not available under fee-for-service (FFS) Medicare. As a result, the program remains incredibly popular and enjoys bipartisan support in Congress.[1] In addition, our member groups see the value and stability in the MA program, as it provides a consistent set of rules and a financing mechanism that allows them to focus on delivering high-quality care, which encourages care coordination. AMGA and our members are invested in the stability of the MA program, and we support policies that will allow plans to continue to offer robust benefits to their enrollees.

We are pleased to offer the following recommendations to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule.

Key Recommendations:

Response to COVID-19 Pandemic
CMS' "extreme and uncontrollable circumstances" policy is linked to Federal Emergency Management Agency (FEMA) designations of a major disaster. Typically, designations are in response to natural disasters, such as earthquakes and forest fires. CMS needs to expand the

[1] Feb. 5, 2020 Letter from Congress to the Centers for Medicare & Medicaid Services

scope of its policy so that it covers situations beyond FEMA major disasters and applies to a public health emergency, including the 2019 Novel Coronavirus (COVID-19) pandemic. CMS should expand eligibility for the policy in the event of a declared public health emergency at the local or state level. CMS also must provide clear and timely guidance to MA plans on how the effect of COVID-19 will factor into benchmarks, rate adjustments, and star ratings.

End-Stage Renal Disease (ESRD) Benchmarking
CMS should ensure that the ESRD benchmarks for MA account for the true costs of treating this patient population. AMGA believes that MA will be an attractive program for patients with ESRD, but the reimbursement structure must accurately account for their expenses.

Medicare Advantage and Cost Plan Network Adequacy
CMS should monitor the effects of this proposal on plan network makeup and beneficiary access to in-person providers, as we believe it is important for beneficiaries to maintain access to in-person providers. While AMGA has long been a strong supporter of telehealth, the technology should be in place to supplement, rather than supplant, providers in a network.

Medicare Advantage and Part D Prescription Drug Program Quality Rating System
CMS should delay any changes to the quality rating system until after the public health emergency resulting from COVID-19 subsides.

Special Supplemental Benefits for the Chronically Ill (SSBCI)
AMGA supports the proposal to expand the definition of *chronically ill* for supplemental benefit purposes so that it includes any chronic condition that is "life threatening or otherwise significantly limits the health or function" of the beneficiary.

Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes
AMGA supports CMS' efforts to better integrate care for this vulnerable population of beneficiaries. However, if finalized, we urge CMS to implement this provision so that it minimizes disruption to the care of beneficiaries currently enrolled in D-SNP look-alike plans.

Beneficiary Real-Time Benefit Tool
AMGA supports CMS' proposal, as we believe that it is helpful for beneficiaries to have access to information regarding the cost of their prescription drugs. This information could have a positive effect on medication adherence and produce positive clinical outcomes for patients.

Out-of-Network Telehealth as Plan Option
CMS is proposing to expand telehealth services by allowing plans to cover out-of-network telehealth as a basic benefit. AMGA opposes this policy, as it has the potential to discourage patients from receiving care from their in-network provider.

Permitting a Second, ''Preferred'', Specialty Tier in Part D
AMGA agrees with the proposal to allow Part D plans to include brand-name and generic drugs on the preferred specialty tier.

Comments

Response to COVID-19 Pandemic
AMGA appreciates that CMS has issued a number of waivers in response to the COVID-19 pandemic. These waivers include flexibilities to waive referrals, streamline cost-sharing requirements, and other changes. Looking toward plan year 2021, however, CMS should take additional action and provide clear guidance on how the pandemic will factor into bids, benchmarks, and rate adjustments. Plans, and their partners in the provider community, will need this information as soon as possible.

CMS also should reconsider linking its "extreme and uncontrollable circumstances" policy to Federal Emergency Management Agency (FEMA) designations of a major disaster. While such designations usually are in response to response to natural disasters, such as earthquakes and forest fires, AMGA recommends that CMS expand the its policy so that public health emergencies are included.

End-Stage Renal Disease Benchmarking
CMS is proposing to codify requirements in the 21st Century Cures Act by removing the prohibition for Medicare beneficiaries with end-stage renal disease (ESRD) from enrolling in an MA plan. As noted in our comments on 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," it is crucial the benchmarking and payment methodologies for ESRD beneficiaries accurately account for the cost of providing care to this vulnerable population. AMGA is concerned that by calculating ESRD benchmarks at the state level, rather than the county level, the benchmarks will not capture the variation in expenses across a particular state. This may result in underpayments in more expensive parts of a particular state.

CMS also has acknowledged that current ESRD reimbursement likely will result in premium increases, as plans will need to account for the higher costs of treating ESRD patients. CMS is proposing to increase the Maximum out of Pocket (MOOP) limits that beneficiaries are subject to, but this change is unlikely to account for the increased cost of treating ESRD patients. In addition, CMS should be cautious about increased cost sharing for an already vulnerable patient population. Instead, CMS should address the underlying issue and update the MA benchmarks so they reflect the cost of providing ESRD care in a particular region of a state. This will ensure plans and ultimately providers have the resources needed to treat this chronically ill patient population.

MA has the potential to improve the lives of patients with ESRD by providing a range of supplemental benefits. For this to succeed, however, adequate benchmarking is required. Should that situation be left unaddressed, AGMA is concerned that reimbursement problems will cascade and undermine the potential benefits of including ESRD beneficiaries in MA.

Medicare Advantage and Cost Plan Network Adequacy
CMS is proposing to give MA plans a 10-percentage point credit toward the percentage of beneficiaries residing within published time and distance standards for contracting with telehealth providers for certain provider specialty types. Under the proposal, plans would receive a 10% credit when contracting with telehealth providers for dermatology, psychiatry, neurology, otolaryngology, and cardiology. AMGA appreciates CMS' attempt to provide plans

with certain flexibilities, especially in geographies where meeting network requirements can be difficult for plans. Additionally, AMGA has always been supportive of telehealth as an alternative source of care for beneficiaries. However, CMS should monitor the effects of this proposal on plan networks and beneficiary access to in-person providers, as it remains important for beneficiaries retain access to in-person care.

We are encouraged that CMS is not proposing to change how the agency calculates minimum provider requirements and that MA plans would still be required to contract with a minimum number of providers for each specialty type under this proposal. As detailed in CMS' February 2018 guidance on MA network adequacy, organizations "must demonstrate that their networks have a sufficient number of providers and facilities" to ensure adequate access for beneficiaries. We again urge CMS to monitor the effects of this policy on beneficiaries.

Additionally, CMS currently requires that plans ensure that 90% of beneficiaries have access to at least one provider/facility of each specialty type within published maximum time and distance standards. In the proposed rule, CMS proposes to reduce this requirement from 90% to 85% for rural, micro, and Counties with Extreme Access Considerations (CEACs). AMGA supports this flexibility, which would make it easier for MA plans to meet network adequacy requirements in rural areas. This proposal could increase access to MA plans for beneficiaries residing in rural areas, who could benefit from the coordinated care provided by these plans.

Medicare Advantage and Part D Prescription Drug Program Quality Rating System
CMS proposes to increase the star ratings weight for both patient experience/complaints and access measures from 2 to 4. AMGA objects to CMS raising the weight of this measure. While we are supportive of efforts to measure patient experience, CMS should not change any measurements during the COVID-19 crisis or during its immediate aftermath. Even though CMS seeks to implement this change beginning in 2023, the agency should reconsider any changes to the quality rating system for the 2021 plan year, given the uncertainty surrounding the impact of the COVID-19 crisis. As such, we ask CMS not to finalize this policy.

Special Supplemental Benefits for the Chronically Ill (SSBCI)
As part of its continued implementation of the Balanced Budget Act (BBA) of 2018, CMS is proposing to codify in regulation guidance related to the supplemental benefits that MA plans may offer. The BBA included the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, which AMGA strongly supported. In comments on the "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 Draft Call Letter," AMGA recommended that CMS provide MA plans with the flexibility to work with providers to ensure as many patients as possible qualify for this benefit expansion.

CMS is proposing a broad definition of *chronically ill*, including any chronic condition that is "life threatening or otherwise significantly limits the health or function" of the beneficiary. This is a more expansive definition of *chronically ill*, which previously was limited to a select list of conditions. AMGA recommended against such a restrictive definition in previous comments and appreciates that CMS is now taking a broader approach to defining a chronically ill enrollee. AMGA recommends that CMS finalize its proposal.

AMGA also recommends that CMS provide plans with flexibility to develop and target

supplemental benefits to address social determinants of health.

Contracting Standards for Dual-Eligible Special Needs Plan (D-SNP) Look-Alikes
In the proposed rule, CMS cites concerns regarding the use of D-SNP look-alike plans to circumvent requirements that seek to better integrate Medicare and Medicaid. Therefore, the agency proposes that, beginning in 2022, it will "not enter into or renew a contract for a D-SNP look-alike in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals." CMS additionally proposes a plan to transition beneficiaries from a D-SNP look-alike plan into other MA plans or a D-SNP. CMS will use the following criteria to identify these plans: either the bid submitted to CMS projects that 80% or more of the plan's total enrollment will be dual-eligible individuals or actual enrollment based on January enrollment of the current year shows 80% or more of the enrollees are dual-eligible individuals. The agency believes discontinuing these plans will allow for better implementation of provisions in the BBA of 2018 and better and more meaningful care integration for this group of beneficiaries. AMGA supports CMS' efforts to better integrate care for this vulnerable population of beneficiaries. However, if finalized, we urge CMS to implement this provision in a way that minimizes disruptions to the care of currently enrolled in D-SNP look-alike plans.

While we are supportive of CMS' efforts to increase integration for dually eligible beneficiaries, CMS should finalize a policy as soon as possible so that plans can determine how and if they will phase out these products. It is not certain when CMS will finalize this proposed rule, and plans need to be ready to implement any changes that are necessary so they can ensure their enrollees have a smooth transition out of a look-alike product.

Beneficiary Real-Time Benefit Tool
CMS is proposing to add a requirement that would call for Part D plan sponsors to implement a beneficiary real-time benefit tool (RTBT) that would allow enrollees to see "accurate, timely, and clinically appropriate patient-specific real-time formulary and benefit information." CMS proposes to make this requirement effective beginning January 1, 2022. AMGA supports CMS' proposal, as we believe that it is helpful for beneficiaries to have access to information regarding the cost of their prescription drugs. This information could have a positive effect on medication adherence and produce positive clinical outcomes for patients. This tool, coupled with the prescriber RTBT, also can enable increased shared-decision making between the beneficiary and clinician.

Out-of-Network Telehealth as Plan Option
CMS is proposing to expand telehealth services by allowing plans to cover out-of-network telehealth as a basic benefit. As such, non-contracted providers could deliver the additional telehealth benefits as a basic benefit for MA enrollees. While AMGA is supportive of expanding access to care via telehealth, allowing beneficiaries to access this mode of care outside of a plan's network as a basic benefit has the potential to discourage patients from receiving care from their in-network provider and undermine care coordination efforts. AMGA opposes this policy.

Permitting a Second, ''Preferred,' Specialty Tier in Part D
CMS is proposing to allow Part D plan sponsors to have up to two specialty tiers as a way to promote competition and reduce the need for non-formulary exceptions. The rule would codify maximum cost-sharing amounts for the specialty tiers. In 2016, the Medicare Payment Advisory

Commission (MedPAC) endorsed the concept. The proposed rule would establish a cost-sharing mechanism that would allow for a maximum allowable cost-sharing for the highest tier, depending on the plan's deductible, of between 25% and 33%. The second or "preferred" specialty tier would be set at any level, provided it is less than the top specialty tier. CMS should clarify that this additional tier is an additional tier, rather than a replacement for an existing tier. AMGA agrees with the proposal to allow Part D plans to include brand-name and generic drugs on the preferred specialty tier.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact Darryl M. Drevna, AMGA's senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA