BETTER MEDICARE ALLIANCE

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April 3, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Dear Administrator Verma:

Better Medicare Alliance, on behalf of our 143 Ally organizations and 460,000 beneficiary advocates, is committed to ensuring stability and continuity for the 24.4 million Medicare Advantage beneficiaries. We appreciate actions already taken by the agency to better enable Medicare Advantage plans and providers to meet the needs of beneficiaries during this national health crisis caused by the coronavirus (COVID-19), including the most recent waivers made related to the Star Ratings System. These changes will have a positive impact on plans and providers and we look forward to continuing to work together to support the capacity for Medicare Advantage to successfully respond to the needs of beneficiaries through this crisis and beyond.

There are numerous issues yet to be dealt with to ensure Medicare Advantage plans and providers are able to fulfill their mission to provide quality, patient-focused, integrated care in a full risk, capitated framework, and we plan to continue to identify both the issues and possible solutions that need to be addressed for care provided in 2020 and beyond. We appreciate your interest in our input and your willingness to hear from stakeholders on the frontlines as to the right path forward.

We write today, to follow-up on our letter sent March 27, 2020, to offer our recommendations for actions to take through your regulatory authority to ensure that the ramifications of today's crisis do not disrupt the care and coverage, stability and value of Medicare Advantage. Even as so much has been done to address immediate needs, we ask you to take further action to make the accommodations necessary to ensure stability and predictability for beneficiaries in 2020 and avoid disruption in Medicare Advantage in 2021.

BMA requests that CMS consider the following policies in the 2021 CMS MA and Part D Advance Notice and the Final Rule, or wherever appropriate:

Risk Adjustment for CY 2021 and CARES Act Implementation

Due to the national health emergency, in-person visits are limited to essential health encounters only. In response, telehealth technology is being leveraged as much as possible for screening, routine and preventive care, and management of chronic care. The focus for plans and providers, rightly has shifted to ensuring beneficiaries have what they need in the short-term. This includes check-ins with their medical providers to discuss chronic conditions, and screening and care for acute conditions including COVID-19, prescription refills, access to food, and social support. Risk assessment, data collection for risk adjustment, and chart reviews have been reprioritized during the course of the emergency to enable providers to focus on patient care. Under the current risk adjustment system, data collected in telehealth encounters is not allowed to be used in the risk adjustment process. This

contributes to a lack of useable data available to determine an accurate risk score for each beneficiary.

Recommended Actions:
Both to enable attention by essential personnel to the urgent priorities in 2020 and to ensure payments to plans are based on accurate data, BMA requests that CMS take the following actions: (1) use two years of encounter data for risk adjustment for 2021 (2) consider experience based risk scores for beneficiaries with 12 months or more of eligibility during the two-year experience period (3) allow for all telehealth services furnished by an acceptable provider to count towards risk adjustment during the public health emergency; and (4) issue guidance as soon as possible to ensure stability of the risk adjustment mechanism for 2021.

We also ask CMS to consider the impact of the emergency, and the waiving of certain activities on future plans to audit this time period.

In addition, with respect to the recently enacted the Coronavirus Aid, Relief, and Economic Security (CARES) Act, we request that CMS issue guidance on the Medicare sequestration and the Medicare add-on payments for hospitals.

Star Ratings System for 2021

The Star Ratings System has been remarkable in driving quality of care for Medicare Advantage beneficiaries and must be protected. The current COVID-19 health emergency has resulted in significant disruptions in the ability to provide and manage the types of services that are the core elements of the Medicare Advantage Star Ratings System. BMA appreciates what CMS has already done including waiving the requirement of submitting HEDIS and CAHPS data in 2020, and using 2018 data for 2021 Star Ratings calculations.

Recommended Actions:
We ask that CMS continue to monitor the impact of COVID-19 on Medicare and Advantage and Star Ratings and make the appropriate technical changes as needed to ensure administrative activities related to Star Ratings are not pulling resources away from care delivery and beneficiary safety efforts. We also ask CMS to hold off on the proposed changes to the weight of the consumer experience measures, and other changes to the Star Ratings System as presented in the 2021 Parts C and D Proposed Rule.

Protection for Unanticipated Costs

Medicare providers across the continuum of care have been working with CMS and Congress to secure critical funding to continue to provide care. Action to protect plans and risk-bearing providers is imperative given the potential of high, unanticipated excess costs in 2020 due to the costs of treatment for COVID-19 patients, increased costs to retrofit care delivery in response to the emergency, and the 20 percent increase for hospitalizations for beneficiaries with COVID-19 that are paid by plans to hospitals.

Recommended Action:
We ask that CMS monitor the unanticipated costs incurred as a result of the COVID-19 crisis, and work with Congress to put in place appropriate financial protections, such as, excess loss protection for Medicare Advantage. In addition, we ask that CMS utilize 2019 data to determine the 2021 benchmark rate for Medicare Advantage plans. Finally, sharing methodology used in assessment of COVID-19 costs with the plans will better enable them to determine for 2021 bids.

Care for COVID-19 and Medicare Beneficiaries

There are three specific areas associated with caring for COVID-19 beneficiaries and all Medicare beneficiaries. BMA requests the following adjustments: allow updates and enhancements to supplemental benefits during this crisis; allow waivers under Medicare Part B and Part D associated with caring for COVID-19 beneficiaries and make the expansion of telehealth permanent.

Supplemental Benefits
Given the unanticipated imperative for beneficiaries to stay in their homes, there may be supplemental benefits that were not considered during the bid process which could provide relief to beneficiaries in need of certain services. This includes services to address the increased need for food delivery to address food insecurity and nutritional support for seniors who previously may not have qualified for this supplemental benefit, assistance in obtaining medications, and care in the home. Additional benefits and services may also include assistance with functions of daily living, remote monitoring, or assistive technologies for benefciaries.

Recommended Actions:
We ask that CMS allow for mid-year enhancements or modifications to supplemental benefit offerings, authorize waivers for expanded eligibility, and allow changes to supplemental benefits offerings during the COVID-19 emergency. We encourage CMS to expand the eligibility of non-primarily health related supplemental benefits to include enrollees who are not chronically ill, are isolated at home, or have needs that have to be met in new ways due the COVID-19 crisis.

Medicare Part B and Medicare Part D and other Flexibilities
Currently, there is no way to predict the cost of future treatments, accompanying medications, and vaccines under Medicare Part B or Medicare Part D to fight COVID-19. Additionally, there is no way to anticipate the long-term impact COVID-19 will have on those diagnosed with the disease, and any continuing health care needs these beneficiaries might have in the future. Providers have identified numerous flexibilities that are needed immediately to enable patients to receive their medications, including waiving blood tests for medication refills, waiving in-person exams for renewals of certain Durable Medical Equipment (DME), and flexibilities needed for beneficiaries to be transferred to other facilities or receive care at home, when appropriate, to relieve pressure on hospitals and other in-patient facilities.

Recommended Action:
Currently, costs for curative treatment are unknown, and the Medicare Advantage program cannot accurately estimate costs and put in the place the appropriate benefit design. We ask CMS to make the necessary adjustments to ensure consumer protections are in place for beneficiaries infected with COVID-19 and ensure all Medicare beneficiaries have the same access and cost-sharing, by carving-

out curative medications and treatments under Medicare Part B and Medicare Part D from Medicare Advantage for 2021. We also ask CMS to waive or modify testing requirements and in-person visit requirements associated with refills and renewals of prescription drugs and DME for all Medicare Advantage beneficiaries during this time.

Telehealth Waivers
We appreciate that CMS has waived requirements for telehealth as a method for limiting the exposure for beneficiaries and health workforce. These waivers allow providers to offer visits virtually and as a result, we are seeing significant effort by providers to modify their care delivery model to adjust to televisits and provide care to the patients while avoiding in-person risk of exposure.

Recommended Action:
We ask for CMS to consider permitting telehealth to be used for risk assessments, during this period of disruption due to COVID-19. Such a waiver would assist in obtaining data on health status since in-person visits are not advised and many new enrollees as of January 2020 have not yet been seen in-person.

Enrollment of Medicare Beneficiaries with End Stage Renal Disease in Medicare Advantage, Effective January 2021

As required by the 21st Century Cures Act, beginning January 1, 2021, all Medicare-eligible individuals with End-Stage Renal Disease (ESRD) will be able to enroll in Medicare Advantage plans. Despite CMS' recognition that "MA plans will have to cover higher costs for beneficiaries with diagnoses of ESRD, [because they] typically incur higher health care costs,"[1] CMS did not propose any changes to ESRD rates. Outside organizations have predicted much higher costs for Medicare Advantage plans as a result of the enrollment of new beneficiaries with ESRD. Wakely estimated the Medical Loss Ratio for beneficiaries with ESRD across the industry is 112% compared to 86.7% for beneficiaries that do not suffer from ESRD.[2] Similarly, Avalere estimated payment shortfall by Metropolitan Statistical Area (MSA) and found that underpayment is particularly prevalent in New York City, San Francisco, Boston, Houston and Detroit.[3] Moreover, the dialysis market is dominated by two large companies that wield a great deal of leverage in provider network negotiations, making it all the more likely that beneficiaries with ESRD will be relatively more costly for Medicare Advantage plans to cover. For 2021, CMS estimates 41,500 beneficiaries with ESRD will move to Medicare Advantage.[4] We agree that a significant number of beneficiaries in Traditional Fee-For-Service (FFS) Medicare are likely to join Medicare Advantage because Medicare

[1] Coleman, Contract Year 2021 Part C Benefits Review and Evaluation Memorandum, Medicare Drug & Health Plan Contract Administration Group (Feb. 6, 2020), at p.4.
[2] Wakely, Increased ESRD Beneficiary Enrollment Flexibility Presents a Potential Financial Challenge for Medicare Advantage Plans in 2021
[3] Avalere, Analysis of End-Stage Renal Disease Payment Adequacy in Medicare Advantage, Better Medicare Alliance, December 2019, available at https://www.bettermedicarealliance.org/policy-research/resource-library/analysis-end-stage-renal-disease-payment-adequacy-medicare.
[4] Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, proposed rule, 85 Fed. Reg. 9002 (Feb. 18. 2020), Table 25.

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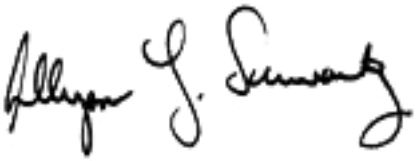
Advantage has a Maximum Out-of-Pocket (MOOP) cap that does not exist in Traditional FFS Medicare.

Recommended Action:
In light of the COVID-19 pandemic and resulting pressures on care delivery and finances of the entire health care system, including Medicare Advantage, we ask that CMS reconsider its approach to payment associated with this policy. Given the uncertain environment, we ask CMS to take the steps necessary to address the payment shortfall and ensure a smooth transition for plans as they take on additional ESRD beneficiaries.

In conclusion, we ask CMS to use its authority through readily available vehicles to address these issues and continue to use its authority to take action to enable the robust response necessary to meet this national health emergency and best enable plans to meet the needs of their beneficiaries, both those with COVID-19 and those with other health needs. We look forward to continuing to engage with you in future conversations as implications of this national emergency evolve and additional impacts on Medicare Advantage become apparent. Thank you for your attention and consideration. Please reach out to Deborah Estes, at destes@bettermedicarealliance.org or (860) 983-7566 with your questions and comments. I am also available, should you wish to reach me directly.

Thank you for your efforts during this national emergency and be safe.

Sincerely,



Allyson Y. Schwartz
President & CEO, Better Medicare Alliance

cc: **Demetrios Kouzoukas**, Principal Deputy Administrator of the Center for Medicare & Medicaid Services;
Cheri Rice, Deputy Director, Parts C and D, of the Center for Medicare & Medicaid Services