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Submitted electronically

RE: Medicare Advantage Value-Based Insurance Design (VBID) Model

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to provide comments in response to the recently announced Medicare Advantage (MA) Value-Based Insurance Design (VBID) demonstration model. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Medicare Rights serves over two million beneficiaries, family caregivers, and professionals through its national helpline and educational programming annually. We believe that VBID—if implemented with appropriate safeguards—can allow CMS to test a model that achieves the triple aim of enhancing beneficiaries' health care experience, improving population health, and reducing costs for people with Medicare.

We appreciate that the demonstration model reflects CMS' careful consideration of many important beneficiary protections. We continue to support strong and clear parameters for program design, including: a multi-stakeholder and transparent process for identifying high-value services and developing conditions of participation; permitting only cost-sharing reductions; limiting or prohibiting advertising and other pre-enrollment marketing of cost sharing adjustments; and opt-in beneficiary selection.[1] Many of these elements are reflected in the program announcement.

Our comments identify components of the VBID model that we support and relay suggestions intended to strengthen the model and ensure that the proposed MA VBID demonstration fully meets the needs of Medicare beneficiaries. These recommendations draw from our counseling experience with beneficiaries who call our

[1] For more, see Medicare Rights' response to the November 2014 CMS Request for Information (RFI) on potential health plan innovation initiatives: http://www.medicarerights.org/pdf/110314-health-plan-innovations-rfi.pdf

national helpline with questions about their coverage under MA, Part D, Medigap plans, Medicaid, and Original Medicare. Our suggestions are also informed by our experience working with beneficiaries who contact us after receiving notices about competitive bidding for Durable Medical Equipment (DME), Fully Integrated Dual Advantage (FIDA) plans in New York State, Accountable Care Organizations (ACOs), and other demonstration programs.

For questions concerning these comments or for additional information, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961 and Casey Schwarz, Senior Counsel for Education & Federal Policy, at cschwarz@medicarerights.org or 212-204-6271. Thank you for the opportunity to provide comments.

General Program Design:

We commend CMS for many aspects of the VBID demonstration model. In particular, we are pleased to see many essential beneficiary protections reflected in the design, including: an allowance for only lowered cost sharing and additional benefits for high-value services and care; prohibited marketing of VBID programs; and the retention of anti-discrimination rules. We fully support the conditions of participation for plans—MA plans under sanction and plans with below-average star ratings should not be permitted increased flexibility. We also support the educational requirements and rigorous evaluation, monitoring, and auditing schemes outlined in the announcement.

Utilizing only positive reinforcement in the form of lowered cost sharing and expanded benefits is an essential component of VBID demonstration models. We strongly commend CMS for allowing only encouragement to access high-value services. As this model is tested and as educational activities are implemented and evaluated, we will support only this incentive. Similarly, we do not support waiving existing anti-discrimination rules. As such, we are glad the model maintains the obligation to provide services that do not target or disincentivize participation or enrollment by health or disability status. We strongly support CMS' proposed monitoring of plan design for discriminatory elements.

Specific Plan Design:

Apply lessons learned and potential successes beyond Medicare Advantage. We are hopeful about the prospects for VBID, and the identification and promotion of high-value services, to improve care and reduce costs for Medicare beneficiaries. While we recognize that CMS' demonstration model is restricted to MA plans, we note that recent legislative proposals concerning VBID have explicitly sought to prohibit the U.S. Department of Health and Human Services from expanding any VBID demonstration beyond MA to the Original Medicare program.[2] The rewards of intelligently structured insurance, including "encourag[ing] patients to consume high-value clinical services, thereby improving quality and reducing costs" should, to the extent possible, be applicable to all Medicare beneficiaries, regardless of how they choose to access their benefits. Lowering or eliminating cost sharing in Original Medicare, as well as offering some of the other positive incentives outlined in this proposal, could also benefit the majority of beneficiaries who choose to remain in Original Medicare.

Should this demonstration result in positive health outcomes for MA enrollees, we hope that CMS will both make lessons learned from this model publically available and, as appropriate, integrate promising practices into the

[2] H.R. 2570 – the *Strengthening Medicare Advantage through Innovation and Transparency for Seniors of 2015*

Original Medicare program and beyond. Thus, we encourage CMS to evaluate this demonstration program—through design, implementation, and monitoring—in light of how positive results might be expanded beyond the MA program.

Make the rationale for identifying "high-value" care publicly available. While we appreciate that CMS will be vetting plan criteria for identifying high-value services, we urge CMS to make this rationale publicly available, either as part of the demonstration or along with the evaluation of the demonstration. We appreciate that VBID has the potential to enhance health care transparency—both for cost and quality. As demonstrated by the literature, diminished cost sharing through VBID also has the potential to improve adherence and health care outcomes, particularly among lower-income, vulnerable populations.[3]

As such, we believe that transparency in the process for identifying high-value services, and particularly high-value providers, is essential. As noted above, this transparency would help facilitate a translation of positive outcomes in the MA arena into actionable steps in Original Medicare and other health systems.

Along these same lines, we encourage CMS to limit approval of lower cost sharing only to instances where there is a well-established evidence-base that illustrates a particular service, prescription medication, or health care provider is in fact "high-value." We also encourage to CMS to develop a standardized list of health care services or prescription drugs that may be subject to altered cost sharing in consultation with clinicians and other experts.

Consider low-income Medicare beneficiaries as you review program design. As CMS reviews MA VBID programs submitted by interested plans, we suggest that the agency carefully consider how the design might impact low-income beneficiaries. For instance, a VBID program overly reliant on reduced cost sharing as an incentive for participation is unlikely to benefit an MA enrollee with both Medicare and Medicaid or a person enrolled in the Qualified Medicare Beneficiary (QMB) Medicare Savings Program. These beneficiaries are protected from liability for most copayments and deductibles.[4]

In contrast, we expect that eliminating Part D copayments could be effective since, even at the Low-Income Subsidy (LIS) level, prescription drug copayments can be a heavy burden for LIS enrollees who need multiple medications. The demonstration could provide valuable data about the validity of that assumption.

Rigorously monitor access to high-value health care providers. Another element of program design where we have specific concerns involves access to high-value providers. We appreciate that implementing network adequacy requirements similar to those that apply to MA plans more broadly may be overly burdensome, but we suggest that CMS carefully monitor access and communication regarding the availability of preferred providers. In particular, we urge CMS to ensure that high-value providers identified by participating MA plans are accepting new patients, so as not to put some MA enrollees eligible for VBID benefits at an automatic disadvantage. In addition, we suspect that communicating to beneficiaries about these tiered networks may be especially challenging. As described below, we encourage careful development and review of all beneficiary communications related to the VBID program, including how to access high-value health care providers.

On this subject, we see potential parallels to preferred pharmacy networks and reduced cost sharing in the Medicare prescription drug program (Part D) and we request that CMS actively evaluate MA plans for geographic and

[3] V-BID Center, "V-BID in Action: The Role of Cost-Sharing in Health Disparities" (July 2014), available at: http://vbidcenter.org/wp-content/uploads/2014/10/Health-Disparities-Brief-July-2014.pdf
[4] 42 CFR 422.504(g)(1)(iii)

urban/rural differences in access to high-value providers. As applicable, we encourage CMS to apply lessons learned from recent initiatives, including the agency's analysis on beneficiary access to preferred cost sharing pharmacies and modifications to nomenclature on preferred pharmacy arrangements, to the VBID demonstration.[5] Importantly, CMS must ensure that VBID models do not benefit only geographic, economic, or other subsets of MA enrollees.

Evaluation and Monitoring:

We strongly support the evaluation processes and related protections outlined in the announcement. The included enrollee protections, like marketing prohibitions, are of little effectiveness unless compliance is monitored and enforced. For this reason, we are pleased that CMS will use "secret shoppers" to help ensure compliance with the model's marketing protections. We also support the auditing procedures and the customized scripts for 1-800-MEDICARE.

As the program is implemented, we suggest that CMS' audit results be made public and that diverse stakeholders are engaged and included in the process of developing the 1-800-MEDICARE call scripts. In addition, we appreciate the ongoing monitoring of plan data for coding intensity, enrollee outcomes, enrollee satisfaction, and other factors, and we would recommend that the incoming data, as well as any results or actions that result from the monitoring, be made transparent and publicly available.

Furthermore, while we commend the requirement for a standardized process for receiving and reviewing provider complaints, we recommend that MA VBID program enrollees receive clear communication from CMS on their right to file grievances and appeals and that the model's data collection include information regarding enrollee grievances and appeals.

We also urge CMS to consider establishing an independent ombudsman program for the purposes of monitoring and assisting beneficiaries in all demonstration programs underway at the Center for Medicare & Medicaid Innovation (CMMI), including for the MA VBID program. Ombudsman programs are being successfully used in the Financial Alignment Initiative for dually eligible beneficiaries as well as to monitor the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program. These entities are responsible for monitoring beneficiary access to care, in addition to limiting beneficiary confusion and promoting enhanced understanding. With an increasing number of delivery and payment system models ongoing at CMMI, we believe a dedicated ombudsman is warranted.

Disallowed Marketing to Beneficiaries:

We strongly support CMS' approach to limiting plan marketing as outlined in program announcement. We applaud the agency for its focus on the potential for enrollee confusion and we appreciate the steps proposed to minimize such confusion. Specifically, we endorse the prohibition on the marketing of any VBID program to beneficiaries not currently enrolled in a participating MA plan.

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[5] Centers for Medicare & Medicaid Services (CMS), "Analysis of Part D Beneficiary Access to Preferred Cost Sharing Pharmacies (PCSPs)," (April 2015), available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/PCSP-Key-Results-Report-Final-v04302015.pdf; Centers for Medicare & Medicaid Services, Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (April 6, 2015), *available at:* http://www.cms.gov/Medicare/HealthPlans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf

We believe this prohibition reduces the potential for "cherry picking" of prospective plan enrollees and other potentially discriminatory practices. In addition, this prohibition ensures that individuals attracted to a VBID program who are not ultimately eligible (because they do not have the requisite health condition(s) or do not need certain services associated with the VBID program) do not end up enrolled in an MA plan that otherwise might not be the best choice for them.

We also support permitting participating MA plans to convey information about VBID benefits only after a potential enrollee specifically inquires about them and only after the provision of a CMS-standard disclaimer concerning the program and potential eligibility. Further, we encourage CMS to require prior review and approval of all written materials, including scripts for oral communication and distribution plans for materials concerning VBID benefits.

Beneficiary and Provider Education and Outreach:

Develop uniform beneficiary communications and revisit minimum requirements. We appreciate the minimum requirements for beneficiary communication included in the program design, but we are concerned these requirements fall short of ensuring full understanding among MA enrollees who might access VBID benefits. Like CMS, we do not believe the VBID model will be successful if MA plans adhere only to the minimum requirements outlined by CMS.

To promote beneficiary understanding and choice, we encourage CMS to modify the proposed requirements. First and foremost, we suggest that CMS develop and require the use of standardized templates for use by participating MA plans in the VBID demonstration. At a minimum, CMS should require that all enrollee communications include plain language information about options, rights, and services in the VBID program. These communications should also direct enrollees to 1-800 MEDICARE and State Health Insurance Assistance Programs (SHIPS) that can help enrollees navigate any confusion or problems with access to care.

In addition, we suggest that CMS ensure all enrollee communications are fully accessible to enrollees and their caregivers. We suggest robust enrollee testing as well as formatting requirements. In recent CMS demonstrations, such as the Financial Alignment Initiative for dually eligible beneficiaries, we have seen first-hand the importance of beneficiary testing of notices and materials prior distribution.

As such, we strongly encourage CMS to ensure that all VBID-related materials are tested through beneficiary focus groups. At a minimum, we suggest that CMS engage with our organization and other consumer advocacy groups who have experience developing and vetting these types of beneficiary communications. We also expect CMS will require all enrollee communications to be linguistically and culturally competent and be available in alternative formats, such as Braille, CD, large-font print, and sign language translation. As educational materials are developed, we also encourage CMS to actively engage with SHIPs and to make relevant information available through other channels, including Medicare.gov and the Medicare & You handbook.

Establish a clear strategy and requirements for health care provider education and outreach. We are concerned about the lack of detail included in the program announcement with regard to provider education. From an enrollee perspective, adequate provider education is just as important as enrollee outreach for ensuring a smooth programmatic rollout. We do not believe that cost sharing alone is an appropriate trigger to steer beneficiary utilization. Medicare beneficiaries participate in a complex health care system, where health care providers largely

direct treatment decisions. For the proposed VBID model to be successful, it must include complementary educational initiatives for both beneficiaries and health care providers.

This requires targeted provider outreach that both explains the purpose of the VBID model, as well as addresses provider's practical concerns. The VBID announcement does not include detailed information for or direction to participating plans about provider education, nor does it define CMS' role in provider outreach. We suggest that provider outreach focus on contracting details and include a clear explanation of any new billing practices and procedures. We urge CMS to consider outreach to all Medicare providers who may interact with enrollees in the new VBID model.

Recent demonstrations underscore the importance of ensuring community-based service providers receive outreach and training about new health care systems, as these providers are often the trusted entities beneficiaries turn to with questions. For example, the need for an effective outreach and education strategy for reaching affected health care providers is a significant takeaway in the early implementation stages of the Fully Integrated Duals Advantage (FIDA) financial alignment demonstration in New York State.

Through the Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE), our organization is working with like-minded community-based organizations, health plans, state agencies and other stakeholders to shape this demonstration. Our early observations of the program have demonstrated a general lack of health care provider engagement in the demonstration's development phases, and we believe this contributed, in part, to a slower rate of beneficiary enrollment than anticipated.

Continued Stakeholder Engagement:

Finally, as the model is updated and revised, we strongly encourage CMS to actively solicit feedback from diverse stakeholders, including consumer advocacy organizations. Developing a model with this level of complexity necessitates an ongoing, structured stakeholder input process with genuine opportunities for beneficiaries, their caregivers, and their advocates to provide feedback on design and implementation issues. It is not sufficient to discuss the general outlines of a demonstration with stakeholders. Details matter and those details are found in documents—in notices, in contracts, in manuals, etc. For stakeholder participation to be genuinely effective, key planning and operational documents must be available for stakeholder review and input.

We appreciate the emphasis in the model to collect and monitor plan data to protect against adverse implications for beneficiaries. As noted above, we request CMS share this data with stakeholders, along with any other evaluation and oversight information, in a timely and transparent manner. Beneficiaries and other stakeholders, as well as regulators, need access both to evaluations and to the underlying data about demonstration results.

As the proposed announcement details an evaluation process, we encourage CMS to ensure that stakeholders have access to all the information that they need to independently evaluate the demonstration's performance. Further, it is important that reporting schedules for key performance information are designed so that issues can be spotted early and mid-course corrections can be effectuated. As the VBID model is proposed as a demonstration, we expect CMS will continue to share information with stakeholders and make necessary improvements to the program based on stakeholder feedback.