MEDPAC | Medicare Payment Advisory Commission

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Chiquita Brooks-LaSure, M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-4205-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled "Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications," published in the *Federal Register*, vol. 88, no. 219, pp. 78476–78630 (November 15, 2023). We appreciate your staff's work on the notice, particularly considering the competing demands on the agency. We hope that the comments we offer below are helpful.

The proposed rule includes many provisions that would revise regulations for the Medicare Advantage (MA) program (Part C) and the prescription drug benefit program (Part D). Our comments focus on the following provisions:

- Expanding network adequacy requirements for behavioral health
- Additional changes to an approved formulary—biosimilar biological product maintenance changes and timing of substitutions
- Amendments to Part C and Part D reporting requirements
- Agent/broker compensation
- Increasing the percentage of dually eligible managed care enrollees who receive Medicare and Medicaid services from the same organization
- Contracting standards for dual-eligible special needs plan (D–SNP) look-alikes
- Limiting out-of-network cost sharing for D–SNP preferred provider organizations (PPOs)

Expanding network adequacy requirements for behavioral health

MA organizations are statutorily permitted to select the providers from whom their enrollees must seek care, as long as they ensure that the network of those providers is sufficient to provide timely access to the full Medicare benefit and any supplemental benefits plans choose to offer. For the 2021 plan year, CMS codified standards for network adequacy related to the minimum number of providers required to cover a service area, and maximum time and distance between those providers and prospective enrollees. Thirteen facility types and 27 provider types have been subject to these standards. Beginning in 2024, network adequacy standards will apply to two new behavioral-health-related specialty types—clinical psychology and clinical social work.

The Consolidated Appropriations Act, 2023, established a new benefit category for marriage and family therapist (MFT) services and authorized payments under Part B for services furnished by MFTs and mental health counselors (MHCs). CMS has recognized that certain services offered by these specialists require particular expertise, and thus in order for MA plans to meet the new coverage standards, they will need to establish network adequacy requirements for these specialists. For 2025, CMS proposes to add a new facility-specialty type to network adequacy standards: outpatient behavioral health (OBH). OBH would be a hybrid designation that could include a mix of individual clinician specialists that typically operate in outpatient clinic settings (including MFTs, MHCs, and addiction medicine specialists), as well as opioid treatment programs, community mental health centers, and other outpatient behavioral health/addiction medicine facilities. The proposal would also add OBH to the list of specialties eligible for the 10 percent credit toward time and distance standards for telehealth provision.

CMS's rationale for creating this hybrid facility-specialty type, rather than individual provider-specialty types, is threefold. First, the services covered by this group of specialists are often provided in outpatient clinic settings, alongside other related services and provider types. Second, the number of Medicare claims for MFTs and MHCs is limited, and more data are needed to establish appropriate time and distance standards for network adequacy. Third, there is precedent for combining certain clinician specialty types into a facility designation for network adequacy purposes; this approach is currently taken for physical therapy, occupational therapy, and speech therapy.

Comment

We commend CMS for its commitment to ensuring that MA enrollees have adequate access to the full range of statutory benefits of the Medicare program, including behavioral health care. The Commission has long been concerned about treatment of behavioral health in the Medicare program, and especially the adverse impacts of opioid use on Medicare beneficiaries.[1,2,3] We support the proposal to expand network adequacy requirements for behavioral health, which recognizes that Medicare beneficiaries have a wide range of

[1] https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch6_MedPAC_Report_To_Congress_SEC.pdf.
[2] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-5-polypharmacy-and-opioid-use-among-medicare-part-d-enrollees-june-2015-report-.pdf.
[3] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch16_sec.pdf.

behavioral health needs and allows for flexibility in provider configurations to reflect variation in practice patterns across local areas.

We acknowledge the challenges associated with establishing network adequacy standards for new specialty types, especially those that provide services that are newly covered by Medicare. However, we encourage CMS to consider the implications of combining MFT, MHC, community mental health centers, opioid treatment programs, and other addiction medicine specialists into a single facility type. As currently proposed, we are concerned that the OBH facility type could lead to networks of providers that are equipped to provide only a subset of the services intended to be covered by the facility type. For instance, plans might be able to satisfy network adequacy requirements with a robust network of MFTs and no opioid treatment centers, or vice versa.

The Commission encourages CMS to monitor access to the full range of clinicians in this new facility type, and to consider developing separate facility or specialty designations for providers of distinct service types if there is evidence of access challenges. For example, CMS could contemplate creating a separate category for substance use disorder/addiction medicine to ensure that beneficiaries in MA plans have adequate access to those services. To address concerns about the appropriate minimum number of providers and time and distance standards, in the first instance CMS might benchmark against the network adequacy standards for less-frequently required specialties currently in the HSD table, such as vascular surgery or infectious disease.[4] The appropriateness of these standards can be revisited over time, as claims data accumulate for the new MFT and MHC service lines, and the network adequacy standards can be revised in response.

Additional changes to an approved formulary—biosimilar biological product maintenance changes and timing of substitutions

Part D law and regulations lay out certain requirements for how plan sponsors must develop and operate their formularies. To ensure that beneficiaries maintain access to drugs that were offered by their plan at the time they enrolled, CMS requires plan sponsors to request and receive approval before carrying out most "negative" midyear formulary changes, such as removing a drug from a formulary or setting new utilization management requirements. Plans must also give affected enrollees at least 30 days' advance notice and provide a one-month transition supply. An exception to this requirement relates to the addition of a therapeutically equivalent generic drug to a plan's formulary. In such cases, CMS allows plans to immediately remove the brand-name drug or change its preferred cost-sharing status without advance notice to affected individuals, CMS, or other affected entities. Such generic substitutions are treated as a maintenance change and are exempt from the requirement to provide transition supplies.

In December 2022, CMS proposed to provide greater flexibility around midyear formulary changes by allowing sponsors to immediately substitute an interchangeable biological product for its corresponding reference product, an unbranded biological product for its corresponding brand-name biological product, and a new authorized generic drug for its

[4] https://www.cms.gov/files/document/2024-hsd-reference-file-updated-10182023.xlsx.

corresponding brand-name equivalent without having to first obtain CMS approval.[5] Consistent with the current policy for immediate generic substitution, those new categories of drugs and biologics would be exempt from the requirement to provide transition supplies.[6]

CMS did not finalize the December 2022 proposed rule, and that proposal is still under consideration. The agency is now expanding the proposal to allow biosimilars that are not designated as interchangeable biological products to be substituted through a midyear maintenance formulary change with a 30-day advance notice. CMS also proposes to allow plan sponsors up to 90 days to remove the reference biological product rather than requiring it to be removed at the same time they add a biosimilar product.

Comment

We commend CMS for continuing to examine its formulary procedures for opportunities to increase biosimilar use and strongly support the proposed changes, which strike a reasonable balance between promoting greater biosimilar use and protecting patients from adverse coverage effects.

Because formulary design is the key tool used by sponsors to manage drug benefits and negotiate rebates with pharmaceutical manufacturers, the Commission has consistently supported CMS's efforts to provide plan sponsors with greater formulary flexibility while continuing to ensure beneficiaries have access to needed medicines. Simplifying its review process for a midyear formulary change could encourage sponsors to respond more quickly to market changes and allow them to manage their enrollees' drug spending more effectively. In a 2017 comment letter to CMS, we strongly supported the agency's proposal to expedite midyear formulary changes for certain generic drugs—a policy the agency adopted subsequently.[7] In that letter, we also encouraged the agency to continue to review its procedures and look for other opportunities in which plans might be given greater flexibility to operate formularies without detrimentally affecting beneficiaries' access to needed medications. The Commission also expressed strong support for the agency's December 2022 proposal to allow immediate substitution of interchangeable biosimilar products for the corresponding reference product.[8]

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[5] An interchangeable biological product is a biosimilar that meets additional requirements set forth by the Food and Drug Administration (FDA), such as evidence that switching between the use of biosimilar and reference biological products results in no decrease in effectiveness or increase in safety risk relative to patients strictly using the reference product. Interchangeable products may be substituted for the reference product at the pharmacy, depending on state pharmacy laws. (https://www.fda.gov/media/151094/download#:~:text=An%20interchangeable%20biological%20product%20is,depending%20on%20state%20pharmacy%20laws). In recent draft guidance, the FDA noted that both interchangeable and other biosimilar products may be prescribed in place of the reference product with equal confidence that they are as safe and effective as their reference products (https://public-inspection.federalregister.gov/2023-20141.pdf). The term "unbranded biological product" generally describes an approved brand-name biological product that is marketed under its approved biologics license application (BLA) without its proprietary name on its label. (https://purplebooksearch.fda.gov/faqs#:~:text=A11%3A%20The%20term%20%E2%80%9Cunbranded%20biologic,proprietary%20name)%20on%20its%20label.)

[6] Under the proposed policy, plan sponsors would continue to have the option to provide an affected enrollee who requests a refill with a one-month supply of the reference biological product.

[7] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/01032018_partc_d_comment_v2_sec.pdf.

[8] https://www.medpac.gov/wp-content/uploads/2023/02/02102023_MA_and_Part-D_MedPAC_COMMENT_SEC.pdf.

Generics' share of prescriptions has plateaued at about 90 percent since 2017, with limited opportunity for further generic substitution because of the shift in the pipeline toward biologics. Accordingly, the Commission contends that encouraging the use of biosimilars is an increasingly important means for improving access to biologics and providing competitive pressure that would help restrain price growth.[9] A recent report from the Office of Inspector General found that greater use of biosimilars in Part D could have reduced spending on biologics in 2019, but plans' limited coverage of biosimilars may have hindered their use.[10] With many more biosimilar products available today, the potential for savings from biosimilars has grown considerably.[11] These savings cannot be realized, however, without formulary coverage.

Amendments to Part C and Part D reporting requirements

CMS currently requires that MA organizations and Part D sponsors report retrospective, aggregate information about topics including plan enrollment, provider payments and incentives, organization determinations and reconsiderations, and enrollee grievances. The information is used by CMS to evaluate plan performance and by beneficiaries making enrollment decisions.

CMS's proposal would amend regulatory language to clarify that CMS can require reporting of more granular information about plan functioning, such as MA plan procedures governing the use of prior authorization or other utilization management tools and the utilization of services and items by plan enrollees. The proposal further clarifies that CMS can require beneficiary-level information in addition to contract-level summary information. CMS pointed to requiring service-level data for MA plan initial coverage determinations and reconsiderations, including decision rationales, as an example of a potential expansion of reporting requirements that would allow better evaluation of the use of prior authorization.

CMS does not propose to make changes to data collection or reporting requirements with this rule.

Comment

MedPAC commends CMS for highlighting the utility of reporting requirements to monitor the use of utilization management tools like prior authorization and for clarifying its authority to require MA plans and Part D sponsors to submit more detailed information about how these tools are used. Prior authorization is designed to help health plans determine the medical necessity of services and to minimize furnishing unnecessary services, thereby helping to contain costs and protect patients from receiving unnecessary care. MA and Part D plans are permitted to require enrollees to obtain prior authorization to access certain items and services, a practice that is not widely used in fee-for-service (FFS) Medicare.

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[9] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch2.pdf, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch1_MedPAC_Report_To_Congress_SEC.pdf.
[10] https://oig.hhs.gov/oei/reports/OEI-05-20-00480.asp.
[11] https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf (Chart 10-26).

However, the current reporting requirements are not sufficient to allow CMS and policymakers to assess the extent to which prior authorization is being used appropriately because information is reported in aggregate at the contract level. For instance, we cannot know which types of services are most subject to prior authorization, which services are most often denied, or whether enrollees with certain characteristics are more subject to prior authorization than others. We have similarly limited information about plans' denials of claims, such as whether a denial was preceded by a prior authorization request. Without such information, CMS has no way to assess potential disparities in access to care, both among MA enrollees, and in MA compared to FFS.

We support CMS's clarification of its authority to require additional information from MA plans and Part D sponsors. We also encourage CMS to exercise its authority to require more granular information on prior authorization and claims denials without delay. The example specified in this proposed rule (to collect service-level data on prior authorizations and reconsiderations) would substantially improve efforts to monitor access to care for MA enrollees.

Agent/broker compensation

In 2008, in response to concerns about the underlying incentives of MA plans' financial arrangements with agents and brokers, CMS established limits on compensation that were intended to provide incentives for agents and brokers to enroll beneficiaries in the MA plan that best meets their health care needs. CMS established a cap on compensation and required that any administrative payments for services other than enrollment of beneficiaries (e.g., training, customer service, agent recruitment) must not exceed the fair market value for those services.

CMS has again expressed concern that, either directly or through third parties, MA organizations are providing agents and brokers with financial incentives to promote certain plans over others, leading some beneficiaries to enroll in plans that do not best meet their needs. In recent years, some MA plans have provided agents and brokers with bonuses, golf parties, trips, and extra cash and classified such expenses as "administrative." In addition, CMS cites information gathered by the Commonwealth Fund that agents and brokers report receiving up to $125 from an MA organization for the completion of a health risk assessment (HRA) of a new enrollee, about ten times CMS's estimate of the fair market value for such an assessment when provided by nonmedical staff.[12] CMS also believes that growth in overall payments to brokers, by circumventing the cap on compensation, has contributed to the rise in consumer complaints related to high pressure tactics and beneficiary confusion.

Furthermore, CMS is concerned about MA organization payments made to field marketing organizations (FMOs), which are third-party marketing organizations that employ agents and brokers and may conduct other marketing activities such as lead generation or advertising. Specifically, CMS is concerned that the rapid increase in such payments

[12] Leonard, F., G. Jacobsson, M. Perry, et al. 2023. *The challenges of choosing Medicare coverage: Views from insurance brokers and agents*. New York, NY: The Commonwealth Fund. https://www.commonwealthfund.org/publications/2023/feb/challenges-choosing-medicare-coverage-views-insurance-brokers-agents.

indicates that national plans have entered a "bidding war" to secure anticompetitive contract terms with FMOs and their affiliated agents and brokers, and that smaller, local, and regional plans do not have the capital to compete in such a market for broker-assisted MA enrollments.

CMS proposes three changes to existing regulations for MA and Part D plans: (1) prohibiting contract terms between MA organizations and agents, brokers, or other third party marketing organizations that may interfere with the agent's or broker's ability to recommend the plan which best fits a beneficiary's health care needs (e.g., making contract renewal or higher reimbursement rates contingent on higher rates of enrollment or on meeting enrollment quotas); (2) expanding the definition of "compensation" to include payment for administrative services, which would no longer be paid separately; and (3) setting a single agent and broker compensation payment rate for all plans (no longer a cap on "compensation") that includes a one-time increase for administrative services that formerly were reimbursed through a separate payment.

Comment

We support CMS's proposals for revising the agent and broker compensation regulations, which should have a significant impact on agents' and brokers' incentives and the anticompetitive behavior currently found in the market. Medicare beneficiaries deserve assistance that is free from anticompetitive influences when choosing the Medicare coverage option that best suits their health care needs. We also note that the cost of plan payments to agents and brokers (including incentives and rewards such as golf parties and trips) is reflected in MA plan bids and thus is financed by Medicare beneficiaries and taxpayers. CMS should consider whether further revisions to agent and broker compensation are warranted to help ensure that payments for agent and broker services provide value to Medicare beneficiaries and the program. In that vein, CMS should also consider whether additional requirements are needed for FMOs to guard against anticompetitive behavior.

Given that the goal of CMS's proposals in this rulemaking is to ensure that beneficiaries receive information and assistance to help them choose the best plan for their health care needs, the Secretary should consider expanding the State Health Insurance Assistance Program (SHIP). SHIP is a national program that offers one-on-one assistance, counseling, and education to Medicare beneficiaries, their families, and caregivers to help them make informed decisions about their care and benefits. Each state or territory receives a grant to fund its program, allowing SHIP counselors to provide unbiased assistance to Medicare enrollees when choosing between different coverage options. In 2008, the Commission recommended increasing SHIP funding for outreach to low-income Medicare beneficiaries, and we continue to support a higher level of funding.[13] Additional funding for SHIP would allow states and territories to recruit and train more counselors and assist more beneficiaries in choosing which Medicare option is best for them.

[13] See Chapter 5: Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar08_entirereport.pdf.

Increasing the percentage of dually eligible managed care enrollees who receive Medicare and Medicaid services from the same organization

Dual-eligible special needs plans (D-SNPs) are specialized MA plans that limit their enrollment to beneficiaries who qualify for both Medicare and Medicaid. Under the Bipartisan Budget Act (BBA) of 2018, these plans must meet one of three standards for integrating the delivery of Medicare and Medicaid services:

- Coordination-only D-SNPs (CO D-SNPs) must notify the state about admissions to inpatient hospitals and skilled nursing facilities for at least one group of high-risk dual-eligible beneficiaries. These plans do not have to provide any Medicaid services.

- Highly integrated dual-eligible special needs plans (HIDE SNPs) must have a capitated Medicaid contract to provide long-term services and supports (LTSS), behavioral health, or both.

- Fully integrated dual-eligible special needs plans (FIDE SNPs) must have a capitated Medicaid contract to provide Medicaid-covered LTSS, primary care, and acute care. Starting in 2025, they must provide several additional Medicaid-covered services, such as behavioral health.

Another key concept for D-SNPs is the applicable integrated plan (AIP). Any of the three D-SNP types listed above can qualify as an AIP. AIPs must have aligned enrollment, which means that they only serve dual-eligible beneficiaries who are also enrolled in a companion Medicaid managed care plan offered by the same company. AIPs must also meet the HIDE SNP or FIDE SNP standards, or, if they are a CO D-SNP, provide a minimum set of Medicaid-covered services. The AIP concept is important because AIPs must have a unified grievance and appeals process and can integrate other aspects of the enrollee experience, such as member materials.

CMS has also established a special enrollment period (SEP) that lets dual-eligible beneficiaries—and beneficiaries who do not receive Medicaid but do receive Part D's low-income subsidy (LIS) —switch their MA or stand-alone Part D plan outside of the annual enrollment period. Under this SEP, these beneficiaries can switch plans once per calendar quarter during the first nine months of the year. (Efforts to switch plans during the last three months of the year are processed as part of the annual enrollment period and take effect in January.)

The proposed rule would make several changes aimed at promoting the use of aligned enrollment in states that have Medicaid managed care programs for dual-eligible beneficiaries. In these states, companies that operate Medicaid plans would be able to offer only one D-SNP for full-benefit dual-eligible beneficiaries within their Medicaid service area. These D-SNPs would have to ensure, starting in 2027, that *new* enrollees are also enrolled in the company's Medicaid plan and, starting in 2030, that *all* enrollees are also enrolled in the company's Medicaid plan. The proposed rule includes some exceptions that would allow companies with Medicaid plans to offer more than one D-SNP

in certain circumstances (for example, they could offer a separate D-SNP to serve dual-eligible beneficiaries who receive partial benefits).

The proposed rule would also modify when dual-eligible beneficiaries could make mid-year changes to their MA or Part D plan. The current quarterly SEP would be replaced with a monthly SEP that would let dual eligibles select a new stand-alone Part D plan. (This change would also apply to beneficiaries who only receive the LIS.) CMS would also create a new monthly SEP that lets dual eligibles enroll in a FIDE SNP, HIDE SNP, or AIP. Taken together, these changes would make it easier to switch from MA to traditional Medicare, easier to enroll in more-integrated D-SNPs, and harder to enroll in less-integrated D-SNPs.

Comment

We support the proposed changes to promote the use of aligned enrollment in D-SNPs. The Commission maintains that Medicare-Medicaid integration can improve care for beneficiaries with low incomes and has long supported efforts to raise the level of integration in D-SNPs:

- In our March 2013 report, before D-SNPs had been made a permanent part of the MA program, we recommended that the Congress permanently reauthorize D-SNPs with high levels of integration and let the authority for all other D-SNPs expire.

- In our June 2019 report, we examined the amount of overlap between the D-SNP and Medicaid managed care markets. We noted that cases of misaligned enrollment (enrollment in a D-SNP and a Medicaid plan offered by separate companies) were unlikely to lead to any meaningful integration and examined several policies that would promote greater integration in D-SNPs, including a requirement for companies that operate D-SNPs and Medicaid plans in the same state to use aligned enrollment.

- In 2018 and 2022 comment letters on MA proposed rules, we asserted that HIDE SNPs and FIDE SNPs were intended to be more highly integrated than CO D-SNPs and said that both types of plans should be required to use aligned enrollment. FIDE SNPs are already required to use aligned enrollment starting in 2025; the proposed rule would ultimately require HIDE SNPs to use aligned enrollment as well.

CO D-SNPs—particularly those that are not AIPs and those in states that have Medicaid managed care programs for dual eligibles—appear to provide little benefit in terms of integration, but we recognize that CMS has limited ability, given the statutory language in the BBA of 2018, to require these plans to be more highly integrated.

We also support the proposed changes to the quarterly SEP for dual-eligible beneficiaries and LIS enrollees and the creation of a new monthly SEP for integrated D-SNPs. Taken together, the proposed changes are similar to a recommendation in the Commission's March 2008 report to narrow the ability of dual-eligible beneficiaries to enroll in non-SNP MA plans outside of the annual enrollment period.

Contracting standards for dual-eligible special needs plan look-alikes

"Look-alike" plans are conventional MA plans that have some of the same features as D–SNPs (such as richer coverage of supplemental dental, vision, and hearing benefits) but do not have to meet the extra requirements that apply to D–SNPs, such as the need to have a state Medicaid contract and an approved model of care.

CMS has defined look-alike plans as conventional plans where dual-eligible beneficiaries account for 80 percent or more of total enrollment. The agency has taken several steps to limit the use of look-alike plans. Most notably, CMS does not approve new plans that expect to exceed the 80-percent threshold and requires any existing plans that exceed the 80-percent threshold to close. When a look-alike plan is closed, the plan's parent company can transfer the plan's enrollees to a D–SNP (if the company offers one) or to another conventional MA plan that meets certain requirements.

The proposed rule would further limit look-alike plans by lowering the 80-percent threshold to 70 percent in 2025 and to 60 percent in 2026 and subsequent years. In addition, starting in 2027, insurers that are required to close a look-alike plan would be allowed to transfer the plan's enrollees only to a D–SNP.

Comment

We support the proposal to further limit look-alike plans. The Commission discussed the use of look-alike plans in our June 2018 and June 2019 reports and has expressed concern that these plans undermine efforts to develop integrated plans for dual-eligible beneficiaries by encouraging them to enroll instead in plans that provide many of the same extra benefits as D–SNPs but do not integrate Medicaid coverage.

Limiting out-of-network cost sharing for D–SNP PPOs

MA plans may, within certain limits, impose cost sharing for their enrollees that is above or below the cost sharing charged for the equivalent service under traditional Medicare. However, the overall cost sharing under a plan must be actuarially equivalent to that under traditional Medicare, and the cost sharing may not be structured in a way that would discriminate against sicker enrollees (42 CFR 422.100). These rules permit MA plans to charge higher cost sharing for services furnished by out-of-network providers.

In this proposed rule, CMS states that for some Part A and Part B services, D–SNP PPO plans often charge out-of-network cost sharing higher than what would be charged under traditional Medicare and in-network cost sharing similar to the cost sharing under traditional Medicare. CMS expressed concern that these benefit structures may increase payments by state Medicaid programs, increase out-of-pocket costs for some dual-eligible enrollees, lower payments to safety-net providers, and run counter to other policy goals. To address the concerns, CMS proposes to limit the out-of-network cost sharing that D–SNP PPOs may impose for certain services.

Comment

The Commission commends CMS for its attention to the implications of plan benefit design, and we support consideration of policy remedies to address the issues described in the proposed rule. CMS's finding that the cost sharing imposed by D–SNP PPOs is often higher than traditional Medicare for out-of-network services and similar to traditional Medicare for in-network services, however, raises questions about how such plans are meeting the requirement that aggregate cost sharing be actuarially equivalent to the cost sharing charged under traditional Medicare. We encourage CMS to provide additional detail about how actuarial equivalence is assessed and enforced for D–SNP PPOs, and to provide evidence that the benefit packages of D–SNP PPOs charging high out-of-network cost sharing are meeting actuarial equivalence standards.

This detail is relevant for consideration of the proposed policy because it will clarify what effects on beneficiary cost sharing can be anticipated if CMS's proposal to limit out-of-network cost sharing for certain services covered by D–SNP PPOs is finalized. In particular, we encourage CMS to clarify whether cost sharing for in-network services can be reasonably expected to increase under the rule for plans seeking to maintain their current actuarial value and whether such an outcome is an intended consequence of the proposed policy.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael Chernew, Ph.D.
Chair

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