ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

April 6, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

Re: Medicare Program; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2021 and 2022 (CMS-4190-P)

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the proposed rule on Medicare Advantage and Part D.

ACHP is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care. The non-profit, provider-aligned health plans that are ACHP members provide coverage in all lines of business for more than 22 million Americans across 35 states and the District of Columbia. ACHP members offer five of the fourteen 5-star rated Medicare Advantage (MA) plans.

We support the overall direction of this proposed rule, appreciating that CMS has reflected a number of ACHP's previous recommendations, and offer the following comments on the proposed rule:

Executive Summary of Comments

- ***Special Supplemental Benefits for Chronically Ill:*** ACHP urges CMS to consider certain extenuating circumstances where it is not appropriate for enrollees to file a grievance or appeal. We also request CMS allow for a one-year grace period during which a MA plan is not penalized (within reason) for potential issues that arise in the offering of a new, innovative SSBCI.

- ***ACHP supports CMS' proposal to increase the weight of patient experience/complaints and access to further emphasize their importance.*** However, we strongly encourage CMS to reconsider the leap in weight from 1.5 to 4. Currently, clinical outcome measures are weighted 3. Consumer experience is a high priority for ACHP members, yet we would not

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support placing greater importance on sampled measures of experience than on measures of clinical effectiveness.

- ***End-Stage Renal Disease Proposals and Provisions:*** ACHP continues to strongly recommend that the Office of the Actuary analyze the impact of using smaller geographical areas such as Metropolitan Statistical Areas or counties as the basis for ESRD dialysis benchmark rates rather than statewide rates.

- ***Telehealth/Network Adequacy:*** ACHP strongly supports the proposed 10-percentage point credit for plans using telehealth to meet network adequacy requirements for certain providers and the proposed reduced threshold for determining time and distance standards in Micro, Rural and CEAC counties. ACHP requests that CMS also provide clarification regarding the network adequacy exception and customization process.

- ***MA and Part D Prescription Drug Plan Quality Rating System***: ACHP requests that CMS perform additional analysis of the Tukey cut point methodology so plans can project and compare impact on more than just the 2018 Star Ratings. While ACHP supports increasing the weight for patient experience measures, we request CMS consider a more gradual approach and adjust the weight to 3, the same as clinical outcome measures.

- ***Maximum Out-of-Pocket (MOOP) Limits for Parts A and B Services:*** ACHP opposes the addition of a third, intermediate MOOP. We are concerned that the addition of a third MOOP would not result in strong actuarial incentives for more MA plans to offer the lowest MOOP. ACHP offers several alternatives below.

- ***Second Preferred Specialty Tier:*** ACHP supports two Part D specialty tiers to encourage the use of biosimilars.

- ***Beneficiary Real Time Benefit Tool:*** ACHP supports requiring Part D sponsors to implement a real time benefit tool capable of providing beneficiaries with timely, clinically appropriate, patient-specific formulary and benefit information in a beneficiary-specific portal or computer application.

Part C Provisions

Implementation of Certain Provisions of the BBA 2018 — Special Supplemental Benefits for Chronically Ill (SSBCI)

ACHP appreciates CMS considering our recommendation to permit greater flexibility in defining a "chronically ill enrollee." This allows for plans to identify individuals with chronic conditions who may become eligible for SSBCI. ACHP supports CMS' proposal to publish a "non-exhaustive" list of chronic conditions that would qualify an individual for SSBCI. This proposal allows ACHP members to develop MA plan benefit designs that would provide SSBCI to individuals with one or more chronic conditions that are not on the list, provided they fall within the SSBCI definition

parameters. We strongly support this flexibility as our plans are best able to identify the enrollees suffering from chronic health conditions whose health could be most improved by SSBCI.

ACHP appreciates CMS' clarification regarding appeals and grievance procedure requirements for SSBCI but urges CMS to consider extenuating circumstances. ACHP maintains that the existing regulation is insufficient to address the unique circumstances of offering SSBCI. For example, a married couple may have the same MA plan but only one qualifies for SSBCI. The wife may receive different benefits and the husband, confused by this, wants to receive the same benefits. When the husband is told he is not eligible he may file an appeal or grievance. This is not an appropriate basis for an enrollee to seek redress through existing grievances and appeals when specifically related to SSBCI.

ACHP urges the administration to allow for a one-year grace period during which an MA plan is not penalized (within reason) for potential issues that arise in the offering of a new, innovative SSBCI. ACHP member plans are consistently looking for new benefits that will help their patient populations with chronic conditions and note that it can take time for all the "kinks" to be worked out. We encourage CMS to consider adding exceptions for circumstances such as the two above.

Improvements to Care Management Requirements for Special Needs Plans (SNPs)

ACHP supports CMS' proposal to apply the chronic condition special needs plan (C-SNP) enrollee management and model of care submission requirements to dual eligible SNPs (D-SNPs) and institutional SNPs (I-SNPs). ACHP recommends that CMS clarify that "providers" follows the definition of "provider" in 42 CFR § 422.2. We also recommend CMS provide additional details about what constitutes "demonstrated expertise and training."

Dual Eligible Special Needs Plan (D-SNP) Look-Alikes

ACHP supports CMS' proposed policies that establish regulatory requirements for D-SNP look-alikes to better ensure that all MA plans serving predominantly dual-eligible individuals provide coordinated and integrated Medicare and Medicaid services. ACHP also supports the proposal to limit the availability of D-SNP look-alike plans in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll Medicaid beneficiaries. We applaud CMS's decision to not enter into or renew a contract for a MA plan that is not a MA SNP plan based on its actual or projected enrollment of dual eligibles.

ACHP also supports CMS' proposal to codify existing sub-regulatory guidance that prohibits Medicare Advantage organizations from marketing D-SNP look-alikes as if they were D-SNPs. We share CMS' concern that these practices are misleading and designed to confuse enrollees and suggest that the plan abides by standards and provides services that it does not.

End-Stage Renal Disease Proposals and Provisions (ESRD)

While ACHP supports the new enrollment flexibilities for individuals with ESRD, we continue to be concerned about the volatility of benchmark rates after the implementation of 21st Century Cures Act.

The ESRD population is a high cost population due to the use of expensive dialysis services and because this population often has other high cost comorbidities. In addition to dialysis, these beneficiaries are more likely to be hospitalized and use more physician and costly ancillary services. These costs vary significantly between urban and rural areas of a state. As a result, the overall ESRD health care costs in a MA plan's local service area are not likely to be accurately represented under the current statewide approach. This is particularly problematic for MA plans located in urban markets.

ACHP urges the Office of the Actuary (OACT) analyze the impact of using smaller geographical areas such as Metropolitan Statistical Areas (MSAs) or counties as the basis for ESRD dialysis benchmark rates rather than statewide rates. We believe that smaller geographic areas may be a more reasonable approach with growth of this population over time and the cost differences between urban and rural areas. This will better ensure greater accuracy in the acquisition costs that will be removed from ESRD rates and will improve the ability for MA plans to improve the contracts with their respective contracted dialysis provider.

ACHP encourages CMS consider other adjustments for ESRD rates to be developed for smaller geographical areas despite the problem of low case numbers. We understand that using statewide data in constructing these rates addresses the concern of there being too few cases in smaller geographic areas to be reliable. However, ACHP offers alternatives that could account for both low case numbers and region cost variations. For example, county rates could be adjusted using credibility factors. The ESRD county benchmark could, depending upon a credibility formula for the number of ESRD beneficiaries in a county, be the actual county data blended with the statewide data, using the statewide data as a manual rate. In some instances, the county benchmark could be strictly the manual rate of the statewide data for a county with no ESRD data credibility. Or the ESRD county benchmark could be the actual county cost and utilization data if the county ESRD data is deemed to be fully credible. This approach would be similar to the methodology CMS uses for MA Part C and D bids when the plan enrollment is too small to be credible. We encourage CMS to keep an open line of communication with MA plans as it is unclear how these proposals and considerations will factor into their plan bids.

ACHP supports all dialysis cost sharing to be equivalent to in-network rates. Due to the duopoly of providers nationally (85% of patients receiving dialysis from just two providers), MA plans have largely been unable to establish payment rates similar to traditional fee-for-service Medicare. In order to facilitate beneficiary protection and reduce total Medicare spending, we request CMS update section 50.1 of the MMCM Ch. 4 to require all dialysis cost-sharing to be equivalent to in-network and also section 110.1.3 to specify that MA plans must pay for dialysis treatment in all medically necessary cases, not just when temporarily absent from the plan's service area.

ACHP supports additional analysis of the ESRD rates to better understand the volatility of these rates and to make them more accurate and more predictable. We have seen volatility of the ESRD rates in recent years, making these rates difficult to forecast. One potential analysis would be to examine the impact of using 6 years of historical data for the Average Geographic Adjustment to reduce year-to-year volatility.

ACHP encourages CMS to consider creating an ESRD Payment Risk Corridor. As noted in our comments for the Medicare Advantage Advance Notice Part I and II for 2021, ACHP requests that CMS consider through its demonstration authority or other means to implement an ESRD payment demonstration such that the payments to plans are reconciled through a risk corridor-type program. ACHP is recommending a demonstration similar to the overall structure of the payment system in the Part D program. The ESRD population is a high-risk, high cost population in which the financial results of the overall MA plan can be greatly impacted because of a few very high cost cases. Both the size of the population that might move to MA as well as the health/selection risk are highly uncertain in 2021. One secondary impact could be many MA plans moving from the voluntary out-of-pocket maximum to the mandatory maximum out-of-pocket because of the increased enrollment of this high-risk population. In addition, the appropriate elimination of the organ transplant acquisition costs from ESRD payment rates poses timing difficulties for provider contracting.

ACHP would recommend the risk corridors be implemented for at least three years, similar to how corridors were first implemented in the Affordable Care Act for the uninsured population. If the risk corridor program is deemed successful in encouraging MA plans to enroll more ESRD membership, consideration can be given to widening the risk corridors over time.

We look forward to collaborating with CMS on designing this demonstration.

Lastly, ACHP recommends CMS develop standards and guidance for MA plans offering in-home dialysis. As a relatively new flexibility, MA plans are hesitant to move forward without additional guidance from CMS regarding quality and service standards. We encourage CMS to work with ACHP member plans and their quality experts in developing in-home care models.

<u>Telehealth/Network Adequacy</u>

ACHP strongly supports CMS' proposal to give a MA plan a 10-percentage point credit in meeting network adequacy thresholds when it contracts with telehealth providers in certain specialties. The 10-percentage point credit toward the percentage of beneficiaries meeting time and distance standards would be available when telehealth benefits are offered in the following specialty areas: dermatology, psychiatry, cardiology, neurology and otolaryngology. ACHP previously recommended that telehealth services be considered when determining fulfillment of network adequacy requirements. ACHP believes that the availability of the 10-percentage point credit will make a positive and significant impact for the ACHP member plans serving rural or network-sparse regions.

ACHP supports CMS' proposal to reduce the threshold for determining if a MA plan meets time and distance standards in Micro, Rural and CEAC counties. CMS' proposal to reduce the current

threshold that requires 90% of beneficiaries have access to at least one provider and facility of each specialty within the county to 85%of beneficiaries—in Micro, Rural and CEAC counties—is a positive first step in the evolution of time and distance standards.

ACHP members in rural communities often find that there is a more limited supply of physicians, specifically specialists, compared to in urban areas. Providers are more geographically disbursed, making the same time and distance standards that are applicable in metropolitan areas, problematic for smaller community-based plans. Quantitative standards that are overly strict in such areas give the few existing providers extraordinary bargaining power to raise prices. Plan sponsors required to meet those standards are therefore unable to negotiate better rates.

Lastly, ACHP would appreciate CMS clarifying the process for requesting Network Adequacy Customization and Exceptions. While the Medicare Advantage Network Adequacy Criteria Guidance document outlines the application process and permits exceptions to time and distance standards "when the healthcare market landscape has changed or does not reflect the current CMS network adequacy criteria," ACHP seeks examples of circumstances in which an exception would be appropriate.

ACHP also requests that CMS clearly delineate when it is appropriate for a plan to request a customization versus an exception, as the Medicare Advantage Network Adequacy Criteria document does not do so.

<u>Cost Sharing Flexibility</u>

ACHP supports CMS' proposed clarifications of a plan's ability to offer reduced cost-sharing. CMS proposes to codify that a MA plan can provide reduced cost-sharing for items and services that are not basic benefits—and that if a plan should provide those reduced cost sharing amounts, they may only be offered as mandatory supplemental benefits. In addition, CMS states that it would clarify that reduced cost sharing for basic benefits specifically relates to the value of Part A and B benefits. That text, however, does not appear in the proposed regulatory language. ACHP supports the proposal and encourages CMS to finalize such clarifications.

<u>Referral/Finder's Fee</u>

ACHP encourages CMS to consider increased transparency into broker payments and contracts. While ACHP is not opposed to eliminating unnecessary or duplicative regulations, we remain concerned about the lack of transparency into referral fees for agents and brokers. Currently brokers receive a stay-in fee for beneficiaries that remain enrolled in the plan and contract the broker previously facilitated. ACHP acknowledges that this was put in place to incentivize MA member retention. However, with approximately 98% of MA enrollees continuing to enroll in the program, this policy is outdated. In addition, this fee creates an unlevel playing field between ACHP members -- community based, nonprofits -- and their national competitors.

MA and Part D Prescription Drug Plan Quality Rating System (QRS)

ACHP appreciates CMS' efforts to refine the Quality Rating System to ensure that it continues to be a relevant tool that adequately and accurately measures and fosters high quality care and coverage. ACHP encourages CMS to use our member organizations as a resource in the evolution of the Quality Rating System. ACHP member plans have successfully delivered superior value through relationship-oriented practices focused on alignment of goals, payer-provider collaboration and appropriate financial incentives. We offer our assistance and expertise to CMS in developing measure concepts that flow from these best practices.

ACHP supports new methods to identify and remove outliers, but requests that CMS delay finalizing the Tukey methodology. ACHP agrees that this appears to produce more appropriate and accurate cut points provided that CMS test this methodology against more than just the 2018 Star Rating years. In addition, ACHP requests that CMS clarify the multiplier for the Tukey's fences calculation. In some definitions, ±1.5IQR is used to identify "outliers" while ±3.0IQR defines "far out" outliers. ACHP would welcome simulated data using previous years' data to help identify how mean resampling, guardrails, and now Tukey's fences will impact the Star Ratings playing field.

ACHP supports CMS' proposal to increase the weight of patient experience/complaints and access to further emphasize their importance. However, we strongly encourage CMS to reconsider the leap in weight from 1.5 to 4. Currently, clinical outcome measures are weighted 3. Consumer experience is a high priority for ACHP members, yet we would not support placing greater importance on sampled measures of experience than on measures of clinical effectiveness.

As an alternative, ACHP encourages CMS to increase the weight of patient experience/complaints and access to a 3. This places importance on member experience without diminishing the importance of clinical outcomes. It also maintains the integrity of the Triple Aim, in which all three of the components of quality, experience and cost are equally important.

ACHP members are dedicated to the closely aligned and integrated payer-provider model, and as a result are keenly aware of the tremendous impact the current COVID-19 pandemic is already having on quality measurement operations and performance. We urge CMS to consider the impact of triage and availability of services on all performance measures when making decisions about advancements in the QPS program this year. These changes are likely to have long-lasting effects for both providers and payers.

ACHP encourages CMS to implement a consistency measure for plans maintaining overall Star ratings of 4.5 for two or more years and reevaluate the use of outdated improvement measures. Measures of improvement can blur the distinction between high-scoring plans with consistently high performance and those with more opportunity for improvement. For some high-performing plans, the ability to improve upon a particular measure narrows simply because they can top out on performance. For lower performing plans, the ability for improvement is greater even though they are starting from a lower position. ACHP is concerned that some improvement measures are no longer achieving the desired intent of rewarding plans for improvement. ACHP believes that consistency and stability in performance over time should be rewarded equally. This would promote star ratings more appropriately based on performance across the entire range of clinical, patient experience and administrative/compliance measures.

ACHP supports CMS' efforts to eliminate topped out measures and reduce the number of measures overall. ACHP agrees with the Medicare Payment Advisory Commission that there has been a proliferation of measures which yield limited information to support clinical improvement or consumer decision-making, and that dilute quality measures results. For instance, MedPAC found that of the 376 MA contracts with Star Ratings in 2019, 71 contracts had administrative measures averaging 4.5 Stars or higher, but outcomes averaging less than 3.5 Stars. We encourage CMS to continue moving forward with eliminating topped out measures and reduce the number of measures overall. Without such efforts, too many measures, and process measures in particular, increase the documentation and reporting burden for plans and providers and provide little to no benefit to consumers.

Maximum Out-of-Pocket (MOOP) Limits for Parts A and B Services

ACHP opposes CMS' proposal to add a third, intermediate MOOP configuration at the numeric midpoint between the current mandatory and voluntary MOOP limits. We are concerned that the addition of a third MOOP would not result in strong actuarial incentives for more MA plans to offer the lowest MOOP — a benefit that best serves frail and high cost/high utilization enrollees. Further, the availability of three MOOPs raises complexity for enrollees. This proposal would make it more difficult for MA plans to determine which MOOP offers the best "value," and new and existing enrollees would face more confusing choices when selecting a plan.

ACHP thanks CMS for including our recommendation to add length of stay scenarios for acute and psychiatric care. ACHP supports CMS' proposal to add a 3-day length of stay scenario for acute stays and an 8-day length of stay scenario for psychiatric care. Next to physician visits, inpatient services have the highest Medicare utilization, and therefore the largest actuarial value. A larger actuarial value offers greater incentive for a plan to choose the voluntary MOOP.

We offer several alternative approaches to encourage more MA plans to offer the voluntary MOOP, many of which could be accomplished by CMS under existing regulatory authority or through its demonstration authority.

- Raise the voluntary MOOP to an amount that represents the 87th percentile of projected Original Medicare out-of-pocket costs instead of the existing 85th percentile, while retaining the existing 95th percentile for the mandatory MOOP. We believe that by moving the voluntary MOOP and mandatory MOOP amounts closer together it will incentivize plans to move to the voluntary MOOP. MA plan cost sharing has increased significantly over the last 10 to 15 years, yet the voluntary MOOP remained at $3,400 over that same time period, which contributed to pushing more plans to the mandatory MOOP limit. As MA plans increase their cost sharing over time, the voluntary MOOP limit should increase simultaneously. For CY 2022, CMS should consider increasing voluntary MOOP to reflect the 88th percentile, for example.

- Better differentiate the MOOP cost sharing values between voluntary and mandatory MOOP. We recommend that CMS better differentiate the maximum copays between the two

MOOPs for those service categories with high utilization. The two service categories with the highest Medicare utilization are: Primary Care Physician (7a) and Physician Specialist (7d). Currently, the maximum copays for these are the same under voluntary and mandatory MOOPs. In considering which MOOP to offer as part of their overall benefit package, MA plans will take under consideration which MOOP offers service categories that will allow the plan to charge a higher copay that will result in a larger actuarial value of copayments (utilization multiplied by copays). The more service categories that CMS differentiates between the MOOPs, especially for those services with higher Medicare utilization, the more likely an MA plan will choose to offer the voluntary MOOP.

- Add new cost sharing limits for observation services and ambulance services and clearly differentiate the maximum copays for these services in the voluntary and mandatory MOOP copays.

- Vary the cost sharing limits for emergency care/post stabilization, home health services, and physician specialist services. We would recommend adding the service category—primary care physician (7a). Increasing the differential for emergency care / post stabilization is an important service category for increased copays. Increased copays on emergency room care incentivizes members to use the appropriate level of care, e.g., physician visits or urgent care, and not over utilize the higher cost ER services. Also, although we support home health service copay differentiation, it should be noted that home health services copay differentiation does not equate to much actuarial value given its low utilization. In addition, many plans do not impose home health copays primarily because it is difficult to collect copays, and many home health agencies are not set up to collect cost sharing under Medicare.

- We do not recommend any more differentiation in the nominal cost sharing limits for the first 20 days of a skilled nursing facility stay. The current differentiation between the copays is currently reasonable, and the utilization for this service is very low so there is not much of an actuarial value for a nominal copay of $10 or $20 per day on this service category, meaning it will not be much of an incentive for a plan to choose the voluntary MOOP.

- Give additional star credit rating value for a plan imposing the lower voluntary MOOP.

<u>Medicare Communications and Marketing Guidelines</u>

ACHP appreciates that CMS is codifying longstanding policies and guidance in its "*Medicare Communications and Marketing Guidelines."* We encourage CMS to continue to provide policy interpretations of the market and communication guidelines, examples and best practices in their original format, in addition to codifying these policies. The guidelines are frequently used and read by individuals unfamiliar with regulatory and legal text. Retaining the format will reduce potential confusion and mistakes.

In response to CMS' request for comments on how to implement prohibitions related to health plan marketing during the open enrollment period, ACHP recommends that CMS provide specific examples of language that is and is not permitted.

Part D Provisions

Safe Disposal of Drugs

ACHP requests additional clarification on CMS' proposal that MA plans provide information on the safe disposal of prescription drugs when furnishing an in-home risk assessment, in both verbal and written communications. ACHP appreciates the guidance already provided on the steps needed to ensure that medications are safely disposed of and request additional clarification on whether or not the in-home risk assessment extends to outside locations where seniors reside, such as senior-living centers, nursing homes or assisted living facilities.

Eligibility for Medication Therapy Management (MTM) Programs

ACHP supports CMS' proposal to codify existing guidance permitting plans to identify their own criteria for whom to target for the MTM program. We encourage CMS to finalize the provision that would apply existing MTM program standards to at-risk beneficiaries under Section 6064 including that the enrollees must be automatically enrolled with an opt-out and that plan sponsors must offer an annual comprehensive medication review and targeted medication reviews no less than quarterly.

Permitting a Second "Preferred" Specialty Tier

ACHP supports CMS' proposal to permit a Part D plan to have up to two specialty tiers and to establish a maximum allowable cost sharing of 25 percent for plans with a full deductible and 33 percent for plans with no deductible applicable to the higher cost-sharing specialty tier. We agree that this additional flexibility could encourage a lower-cost specialty tier that includes and encourages the use of biosimilars. We expect that it could improve competition among specialty drugs and the ability of Part D sponsors to negotiate better prices with manufacturers and lower costs for beneficiaries. The addition of this second tier could generate plan savings if manufacturers start to offer rebates for specialty drugs on a preferred tier, similar to how preferred non-specialty brand drugs are administered today. Part D plans will likely save on drug ingredient costs as well.

ACHP would also support improving the incentives for plans and beneficiaries to realize greater savings when they need costly specialty treatment and we encourage CMS to study alternative catastrophic reinsurance models to incentivize the greatest savings for plans implementing a preferred specialty tier.

Beneficiary Real Time Benefit Tool (RTBT)

ACHP supports requiring Part D sponsors to implement a Real Time Benefits Tool (RTBT) capable of providing beneficiaries with timely, clinically appropriate, patient-specific

formulary and benefit information in a beneficiary-specific portal or computer application. This support is consistent with previous ACHP comments that encouraged CMS to finalize its 2019 proposal to provide more information on drug coverage and costs to clinicians at the point-of-prescribing through the use of a RTBT. At that time, we noted that prescribers as well as patients need access to three critical pieces of information: clinical appropriateness, coverage and cost. ACHP supports enhancing transparency within the pharmaceutical industry, including for patients and prescribers.

We anticipate that implementation of such a tool across Part D sponsors will not only help lower drug expenditures for the Medicare program, but also improve patient outcomes. Incorporating drug coverage and cost information, including a beneficiary's copayment or coinsurance, at the point of prescribing improves adherence. Beneficiaries may abandon their prescription when taking it to a pharmacy to be filled because they learn it is not covered or too expensive. Providing that information up front to enrollees can reduce such occurrences.

If finalized, ACHP recommends that CMS develop an optional, model tool for all health plans to use. A CMS-developed tool could reduce costs for health plans and help ensure consistent functionality across plans. While we acknowledge that some of the drug pricing information aligns for both the prescriber and beneficiary tools, we are concerned that CMS underestimates the amount of time and costs that are associated with implementing consumer-facing drug pricing tools, and recommend that the start time is delayed until Jan. 1, 2023.

ACHP supports CMS' proposal to allow Part D plans to offer rewards and incentives to encourage consumer use of the real-time benefits tools. ACHP member plans with experience in online price transparency tools report that offering rewards and incentives can build utilization and engagement. ACHP generally supports the $15 per login ($75 in the aggregate annually) cap proposed and suggests CMS implement similar discrimination bans as those required by Medicare Advantage Prescription Drug plans.

<u>Pharmacy Performance Measure Reporting Requirements</u>

ACHP supports CMS' proposal to begin to explore the use of Pharmacy Performance Measures by requiring Part D sponsors to disclose to CMS the measures they use to evaluate pharmacy performance. We agree that additional analysis in this area is important to better understand the growth in the use of financial penalties and other price concessions and the public reporting of those measures can contribute to increasing transparency.

ACHP also encourages CMS to explore the development of consensus pharmacy performance measures for a future Part D Star Ratings program that would assess Part D plan sponsors' uptake of a standard set of pharmacy performance measures or that evaluate the percent of high-performing pharmacies in the sponsors' network.

We strongly recommend, however, that CMS develop these efforts with stakeholders that can contribute based on experience and expertise. CMS should build on best practices of high-quality plans such as ACHP members. Our member plans are community-based, non-profits that have successfully delivered better value through relationship-oriented practices focused on alignment

of goals, health plan and provider collaboration and appropriate financial incentives. We offer our assistance and expertise to CMS in developing pharmacy measure concepts that flow naturally from these best practices and deliver greater value.

Conclusion

Thank you for your consideration of ACHP's comments and recommendations for the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule. ACHP appreciates the Administrations' continued efforts to improve and refine the MA program. We welcome continued engagement on our member plan best practices and efforts to offer evidence based, high quality and consumer focused MA and Part D plans.

If you have questions or require additional information, please contact Michael Bagel (mbagel@achp.org), ACHP Director of Public Policy.

Sincerely,

Ceci Connolly
President and CEO
Alliance of Community Health Plans