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April 6, 2020

Seema Verma, Administrator
The Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8013

Re: CMS-4190-P, Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Administrator Verma:

Better Medicare Alliance (BMA) is pleased to submit the following comments on proposed Policy and Technical Changes for Contract Year (CY) 2021 and 2022 ("Proposed Rule") on behalf of our Alliance and the 24 million beneficiaries enrolled in Medicare Advantage. BMA is a community of more than 140 ally organizations and 460,000 beneficiary advocates who value Medicare Advantage and the affordable, high-quality and coordinated care it provides millions of seniors and individuals with disabilities. Together, our alliance of health plans, provider groups, aging service organizations, and beneficiaries share a commitment to ensuring Medicare Advantage is a high-quality, cost-effective option for current and future beneficiaries.

Seniors and individuals with disabilities eligible for Medicare deserve the value-driven, affordable, quality, and innovative health care available in Medicare Advantage. Through value-based payment and care management that results in quality care, improved health outcomes, extra benefits, and lower costs for consumers, Medicare Advantage is addressing the needs of today's beneficiaries. With growing enrollment and high consumer satisfaction, Medicare Advantage is building the future of Medicare.

Today, Medicare Advantage covers about 35 percent of all eligible beneficiaries. This year Medicare Advantage beneficiaries were able to choose from nearly 4,300 plans with the average beneficiary having access to 39 plan choices in their county. For 2020, Medicare Advantage reported the lowest average premiums since 2007 and the third consecutive year of premium decreases, with 94 percent of beneficiaries having access to at least one $0 premium plan.[1] The decline in premiums over the last three years is estimated to save taxpayers $6 billion in lower Medicare premium subsidies.[2] In addition, 97 percent of Medicare Advantage beneficiaries have access to a plan with dental, vision, hearing, or fitness benefits, and nearly 6-in-10 plans provide all four supplemental benefits. Further, 81 percent of Medicare Advantage beneficiaries are enrolled in four- or five-star plans, the highest ratings for quality.[3] In a recent study, Medicare Advantage beneficiaries reported $1,598 less in total spending than those in Traditional Fee-for-Service (FFS) Medicare.[4] Beneficiaries are highly satisfied, with Medicare Advantage earning a 94 percent satisfaction rating in a recent poll.[5] This year, a record-setting 403 Members of Congress sent bipartisan companion letters to the Administration expressing strong support for Medicare Advantage,

[1] https://www.bettermedicarealliance.org/policy-research/resource-library/medicare-advantage-2020-fact-sheet
[2] https://www.cms.gov/newsroom/press-releases/trump-administration-drives-down-medicare-advantage-and-part-d-premiums-seniors
[3] https://www.bettermedicarealliance.org/policy-research/resource-library/medicare-advantage-2020-fact-sheet
[4] Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Modest-Income Populations, March 2020: Better Medicare Alliance.
[5] https://www.bettermedicarealliance.org/policy-research/resource-library/medicare-advantage-2020-fact-sheet

which serves both as a testament to constituents' satisfaction as well as increasing recognition by policymakers of the value and success of this option for Medicare.[6]

We appreciate CMS' support of Medicare Advantage and believe that this Proposed Rule aims to create a positive environment for Medicare Advantage plans, providers, and community partners to offer Medicare Advantage beneficiaries innovative, high-quality, cost-effective care that improves beneficiaries' experiences and health outcomes. We have comments on several provisions, some of which we briefly highlight in this letter, all of which we detail as comments in the attachment.

As we submit this Comment Letter, we first must acknowledge the health emergency we are experiencing as a nation and the impact it is having on the entire health care system. We commend the Administration for the regulatory actions it has taken to respond, including allowing the use of telehealth as a replacement for regular face-to-face encounters, permitting nurse practitioners and physicians' assistants to extend their work in critical ways, and waiving submission requirements for Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) surveys. We encouraged the extension of both the expansion of telehealth and the changes made for clinical practitioners and would hope for these changes become permanent policy.

Going forward, we encourage CMS to use it authority to ensure plans and providers in Medicare Advantage have the flexibility and tools to meet the needs of beneficiaries directly impacted by COVID-19, as well as all those who continue to have other chronic and acute care needs during this crisis. These issues include: 1) the need to address risk adjustment and risk scores, including consideration of using two years of data for risk scores going into 2021, 2) the importance of excess loss protection for plans, given the uncertainty that 2020 payments will be adequate to meet the outlays, 3) the opportunity for plans to submit mid-year enhancement to supplemental benefits given the changes in care delivery and beneficiary needs, 4) additional guidance to plans related to bids that would better enable plans to calculate costs for COVID-19 in 2021, and 5) assurance that should a new cure become available in 2021 that the cost of the medications under Part D be covered by Medicare directly.

We have sent separate communications to CMS which outline these issues, with recommendations for action. As always, we appreciate the responsiveness and engagement with BMA and the broader stakeholder community as CMS reviews and addresses these issues. The action taken in the upcoming months will be essential to meeting the immediate needs of the victims of this pandemic and are necessary to ensure the continuity and strength of Medicare Advantage to continue to innovate coverage and care for millions of beneficiaries.

As we address the needs of the population of beneficiaries in Medicare there are important proposed changes in policy in the Proposed Rule. Here are highlights of our comments, detailed in the attachment:

> **End-Stage Renal Disease.** BMA shares the Administration's goal to improve care for those with Chronic Kidney Disease (CKD) and sees Medicare Advantage as well-positioned to provide high-quality, integrated care for beneficiaries with End-Stage Renal Disease (ESRD). We welcome the opportunity for Medicare Advantage to care for beneficiaries with ESRD, to slow disease progression for those at risk, and to expand access to transplantation. In order to ensure a smooth transition and successful implementation of this new policy, CMS must address the chronic underfunding and fluctuating nature of ESRD payment in Medicare Advantage, ensure the ESRD benchmark calculations and risk scores reflect actual costs, and provide accurate and adequate payment for this high-need, high-cost patient population. These actions are essential to enabling plans and providers to offer high quality, innovative care and services to those with ESRD, and protect all beneficiaries from increased costs.

[6] https://www.bettermedicarealliance.org/newsroom/press-releases/better-medicare-alliance-helps-set-new-record-bipartisan-congressional

Star Rating System. Given the current demands on plans and providers and the recent decision to waive Star Ratings, it is not advisable to move ahead with an increase to the weight of patient experience, complaint and access measures, or other proposed changes. In addition, there are serious methodological concerns with the calculation of these measures that need to be resolved before they receive more weight. We are planning research to explore improvements to consumer experience measures and we would be happy to submit these findings to CMS when they are available.

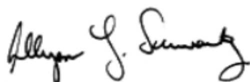
Network Adequacy. BMA supports CMS' proposed changes to network adequacy standards and we encourage CMS to continue its focus on expanding beneficiary access to additional providers. In particular, we support CMS' proposal to modify network adequacy standards by lowering the percentage of beneficiaries that must reside within the maximum time and distance standards in Micro, Rural, and County with Extreme Access Considerations (CEAC) counties. We also ask CMS to consider additional changes to allow Medicare Advantage plans to provide dialysis in a variety of settings and we support the proposed change that provides a 10 percent credit toward time and distance standards for plans that contract with nephrologists for telehealth services, and other providers as CMS included in its proposal.

Maximum Out-of-Pocket Limit. BMA appreciates CMS' understanding that current ESRD reimbursement will not cover the high costs of care for ESRD beneficiaries in Medicare Advantage. However, we do not agree with CMS' proposed solution of increasing the maximum out-of-pocket (MOOP) limit for all beneficiaries by incorporating costs incurred by beneficiaries with ESRD into the MOOP calculation. While some increase in the MOOP may be justified, the current proposal simply raises costs for all beneficiaries. To protect beneficiaries from higher out-of-pocket cost and ensure adequacy of payments, CMS should increase ESRD benchmarks by accounting for the MOOP limit in their calculation.

BMA shares the Administration's commitment to Medicare Advantage payment and policies that ensure adequate and stable resources to offer beneficiaries the care and services they deserve. Recent changes in law and regulations for Medicare Advantage have supported an increase in enrollment, higher provider engagement in value-based payment arrangements, new relationships with community partners, lower consumer costs, and widespread support from policymakers. CMS' support for this integrated care model has driven innovation in financing and care delivery for millions of Medicare beneficiaries. We appreciate your efforts and we look forward to working with you and your staff to ensure Medicare Advantage is able to offer high quality care, lower consumer costs, and extra benefits tailored to meet the needs of current and future Medicare beneficiaries.

Thank you for the opportunity to submit comments and we welcome further discussion.

Sincerely,



Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

CC: Demetrios Kouzoukas, Director, Center for Medicare;
Cheri Rice, Deputy Director, Center for Medicare

Attachment

Better Medicare Alliance's Comments on Proposed Policy Changes

Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

- **Improvements to Care Management Requirements for Special Needs Plans (SNPs) (§ 422.101), Face-to-Face Annual Encounters**

BMA supports implementation of this statutory requirement and supports provision of the encounter via telehealth. We ask CMS to provide clarity surrounding the fulfillment of this requirement.

CMS proposes that SNPs must provide an annual encounter for each enrollee that is in person or through a visual, real-time, interactive telehealth encounter. The encounter may consist of (but is not limited to): visit by member's interdisciplinary care team, annual wellness visit, Health Risk Assessment completion, health education, or care coordination activities.

BMA Comments:

BMA supports CMS in its implementation of this Bipartisan Budget Act requirement and, in particular, supports provision of an annual encounter in-person or via telehealth. Technology that connects patients and doctors offers more timely and efficient use of resources and creates new opportunities to improve care delivery and health outcomes. This includes the use of Interdisciplinary Teams, which is made easier through technologies like telehealth, and improves care for the whole patient. Medicare Advantage is well suited to use these innovations to enhance patient access, reduce costs, and improve health for beneficiaries.

Today, there are two particularly important applications of this technology. One, telehealth is specifically relevant during disease outbreaks, such as we are currently facing with COVID-19. During this time when social distancing and public requirements to "stay home" are in place, telemedicine offers new and potentially transformative options for the delivery of health care. We commend the Administration for allowing the use of telehealth as a replacement for regular face-to-face encounters during this time, and in fact, encourage the extension of this policy permanently. Two, as discussed by the Medicare Payment Advisory Commission (MedPAC), telemedicine can improve patient access to specialty care in rural areas that have difficulty staffing full-service hospitals.[7] Medicare Advantage plans and providers have been leaders in the use of telehealth to improve access and continuity of care and should be encouraged to do so now and into the future.

It is our understanding that CMS will allow any in person or real-time, interactive telehealth encounter to fulfill this requirement, and that completion of a health risk assessment during the encounter is not required. We would appreciate clarification from CMS regarding whether this understanding is correct. In addition, it would be helpful if CMS would provide guidance regarding expected actions when members refuse to participate in an encounter, are unreachable, or are unable to participate via remote technology. We also ask CMS to allow information gained during these and any other telehealth encounters to be included in the risk adjustment process within Medicare Advantage.

[7] https://www.bettermedicarealliance.org/sites/default/files/2018-02/BMA_OnePager_Telemedicine%20in%20Medicare%20Advantage_2018_01_26_v2a.pdf

- **Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514)**

BMA asks CMS to clarify that the 80 percent threshold applies to full-benefit dual-eligible individuals only. BMA appreciates the extension to 2022 for full transition from "look-alikes" to D-SNPs, to allow for a careful transition that allows beneficiaries to choose a new plan that meets their needs and supports continuity of care.

CMS proposes not to enter into or renew contracts for D-SNP look-alikes in a state where there is at least one legitimate D-SNP or other plan authorized to enroll duals exclusively. CMS proposes to define D-SNP look-alikes as plans with a high proportion of duals in non-D-SNPs (80 percent or more). If CMS identifies a plan as a look-alike, the plan will have 3 options: 1) Apply for and contract as a new D-SNP for the following year, 2) Create a new Medicare Advantage plan (or plans) through the annual bid submission process, or 3) Terminate the plan and not submit a bid for the following year. Beneficiaries in plans that cannot continue to operate may enroll in a new Medicare Advantage or Medicare Advantage-Prescription Drug (MA-PD) plan or choose Traditional Fee-For-Service (FFS) Medicare with a Part D plan. If a plan is identified as a look-alike, the plan can transition beneficiaries to another plan it offers, which would allow those beneficiaries to maintain continuous coverage. The proposed transition process would overlap with the annual election period.

BMA Comments:

BMA supports work by CMS, states, D-SNPs, and Medicare-Medicaid Plans (MMPs) to integrate Medicare and Medicaid benefits for dually eligible beneficiaries. This population of beneficiaries can benefit from the care coordination and integrated benefit design available through a managed care plan tailored to their needs.

BMA appreciates that CMS has proposed a definition for D-SNP look-alike plans that is clear and measurable, and we encourage CMS to further clarify if the 80 percent threshold applies to full-benefit dual-eligible individuals. BMA recognizes that "look-alike" plans may undermine state efforts to integrate Medicare and Medicaid benefits through D-SNPs or MMPs and we share the goal of encouraging these state efforts. However, we also know that in some states, and in some markets within states, these managed care plans that coordinate Medicare and Medicaid benefits fill a critical gap in the market where D-SNPs and MMPs are prohibited or otherwise unavailable. While we support the move away from "look-alikes", we hope CMS will recognize the vast diversity of market conditions across the country as it considers policy changes.

Dual-eligible beneficiaries often struggle to navigate Traditional FFS Medicare and Medicaid on their own, and managed care plans that coordinate these benefits provide important benefit navigation and care coordination services. CMS should ensure dual-eligible beneficiaries who have previously been receiving care in a managed care plan do not default into Traditional FFS Medicare. These beneficiaries should have the opportunity and support necessary to choose a new plan that meets their needs and does not disrupt their care.

Implementation of Several Opioid Provisions of the Substances Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

- **Beneficiaries with History of Opioid-Related Overdose Included in Drug Management Programs (DMPs) (§ 423.100)**

BMA strongly supports statutory and regulatory efforts to combat the national opioid epidemic, while sharing CMS' goal of ensuring that any new policies maintain access to pain medication for those Medicare beneficiaries who truly need it.

CMS proposes: 1) to amend the definition of "potential at-risk beneficiary" to include Part D beneficiaries identified as having a history of opioid-related overdose; 2) to define a Part D beneficiary as having a "history of opioid-related overdose" when there is a recently submitted claim with an opioid overdose diagnosis code and at least one recent opioid claim; and 3) to use diagnosis codes that include overdoses of both prescription and illicit opioids, as both are the most predictive risk factors for another overdose or suicide-related event.

BMA Comments:

BMA strongly supports statutory and regulatory efforts to combat the national opioid epidemic. We appreciate the work CMS and Part D plans sponsors are doing, balancing the need to ensure access to medically necessary drug regimens and reduce the potential for unintended consequences among patients already on higher doses of opioids. Medicare Advantage plans are leaders in helping beneficiaries face substance abuse challenges, using supplemental benefit flexibility to offer expanded options for substance abuse treatment. This is done both directly and indirectly by including services such as therapeutic massage, substance use disorder counseling, and through the use of peer recovery support services. Indirectly, this is done by having expanded supplemental benefits such as telehealth and non-medical transportation. In 2020, 192 Medicare Advantage plans offer a therapeutic massage benefit, which is up from 22 Medicare Advantage plans in 2019.[8] We encourage CMS to include such supplemental benefits in the standard Medicare benefit to provide coverage for those in Traditional FFS Medicare and to expand access for all beneficiaries in Medicare Advantage. We ask CMS to update the bid pricing tool so that Medicare Advantage plans are able to indicate if the supplemental benefit is aimed at addressing substance abuse disorder so that the availability and impact of these services can be tracked. We also encourage CMS to ensure adequate access to pain management drugs for those Medicare beneficiaries who truly need such treatment, such as those in hospice or receiving palliative care, or those suffering from cancer, sickle cell, or other diseases.

- **Eligibility for Medication Therapy Management Programs (MTMPs) (§ 423.153), At-Risk Beneficiaries (ARBs) and Medication Therapy Management (MTM)**

BMA commends CMS for seeking a means to engage this challenging population, but we do not recommend CMS move forward with the proposal to automatically enroll at-risk beneficiaries into medication therapy management programs if they do not meet the eligibility criteria.

CMS proposes to require Part D plan sponsors to automatically enroll at-risk beneficiaries (ARBs), i.e., those who are deemed to be at risk of misuse or abuse of frequently abused drugs, in their medication therapy management (MTM) programs on an opt-out basis. Part D sponsors would be required to provide ARBs the same minimum level of MTM as is offered to other beneficiaries in their MTM program, which includes interventions for beneficiaries and prescribers, an annual comprehensive medication review (CMR), and targeted medication reviews (TMRs).

BMA Comments:

[8] https://www.bettermedicarealliance.org/sites/default/files/2018-12/20181207%20Milliman%20-%20MA%202019%20Supplemental%20Benefits%20-%20Final.pdf

Because Medicare Advantage plans manage both the medical and drug benefits, they are particularly well-equipped to engage in care coordination with medical providers to identify at-risk beneficiaries and ensure patient safety and the medical appropriateness of prescribed medications. BMA supports the regulatory actions CMS has taken in the past several years to allow Medicare Advantage plans to employ utilization management tools in cases where drugs have a high potential for misuse. In recent years, plans are being asked to use utilization management and other tools to identify patients who might be misusing or misdirecting opioids. Since 2019, Part D plans have implemented specific controls for opioid prescriptions, such as limits on initial opioid fills for acute pain to no more than a seven-day supply and requirements for pharmacists to engage with the beneficiary's prescriber for opioid prescriptions above a certain dosage. Part D plans also have new tools to help further deter opioid misuse, including the ability to implement drug management programs that limit access to opioids for certain at-risk beneficiaries. Medicare Advantage plans have already implemented these and other strategies to deter opioid abuse and misuse.

However, we do not support the proposal to automatically enroll at-risk beneficiaries into MTM programs. This population is hard to reach, and often do not meet the standard MTM criteria. Instead, we support allowing Medicare Advantage plans to incorporate parts of the MTM program into their Drug Management Program, including Targeted Medication Reviews, beneficiary outreach, and beneficiary education.

Implementation of Certain Provisions of the 21st Century Cures Act

- **Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)**

BMA supports the right of newly eligible Medicare beneficiaries with ESRD to seamlessly convert to a Medicare Advantage plan from a health plan offered by the Medicare Advantage Organization. We believe seamless conversion will improve care continuity for this vulnerable population.

CMS notes that § 422.66(d)(1) requires Medicare Advantage Organizations to accept enrollment in their Medicare Advantage plans by newly-eligible Medicare beneficiaries who are seamlessly converting from health plan coverage offered by the Medicare Advantage Organization and who are otherwise eligible. CMS notes that § 422.66(d)(1) provides that the right to seamlessly convert to a Medicare Advantage plan applies regardless of whether the individual has ESRD. CMS seeks comment on this issue.

BMA Comments:

BMA supports seamless conversion as a way to improve continuity of care for beneficiaries and reduce complexity and confusion surrounding the Medicare enrollment process. BMA believes seamless conversion may be particularly helpful for newly-eligible Medicare beneficiaries with ESRD who are at particular risk of health complications and adverse events resulting from disruption in care.

As CMS continues to consider the impact of ESRD beneficiary enrollment changes for Medicare Advantage, BMA asks CMS to update the Bid Pricing Tool so that the ESRD subsidy is moved under Medicare covered benefits from mandatory supplemental benefits. The majority of expenses associated with caring for ESRD beneficiaries are Medicare covered services, and funding should not come out of rebate dollars as it does today. This change will ensure rebate dollars are available for use as supplemental benefits for non-ESRD beneficiaries too, including those who have chronic conditions, multiple co-morbidities and social risk factors. This change would be meaningful in enhancing the ability to provide quality, innovative care for ESRD patients and to meet the needs of other non-ESRD beneficiaries who rely on these benefits and cost savings.

- **Exclusion of Kidney Acquisition Costs from Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)**

BMA asks CMS to provide additional details regarding how it proposes to calculate organ acquisition costs for kidney transplants.

CMS proposes to exclude kidney acquisition costs from the benchmark beginning in 2021 as required by 21st Century Cures Act.

BMA Comments:

BMA asks CMS to provide additional detail regarding how it proposes to calculate organ acquisition costs for kidney transplants. Per the *21st Century Cures Act*, these costs are to be covered by Traditional FFS Medicare and thus eliminated from both the benchmark and plan bids. However, CMS has not provided critical details such as the exact codes it plans to eliminate from the benchmark. This information is key to ensuring accuracy of both benchmarks and plan bids.

- **Out-of-Network Telehealth at Plan Option**

BMA supports the treatment of additional telehealth benefits as a basic benefit under Medicare Advantage and urges CMS to finalize this policy as proposed.

CMS is considering whether to allow non-contracted providers to offer additional telehealth benefits (ATBs), and treat them as basic benefits under Medicare Advantage, if they comply with established requirements. CMS believes requiring non-contracted and contracted providers to meet the same ATB requirements will ensure ATBs are delivered in a manner consistent with the statute and plans will have necessary control over how and when services are furnished. Currently, PPOs do not need to cover ATBs out-of-network but may do so as a supplemental benefit.

BMA Comments:

BMA strongly supports the Bipartisan Budget Act of 2018 provision that permits Medicare Advantage organizations to offer additional, clinically-appropriate telehealth benefits in the annual bid, above and beyond the services currently reimbursed under Medicare Part B, beginning with the 2020 plan year. BMA also supports the regulatory environment CMS is creating to foster robust provision of telehealth services within Medicare Advantage, giving beneficiaries a choice between seeing a provider in-person or via telehealth. Evidence indicates that certain telemedicine services enhance access to care, improve quality, and reduce costs for chronically ill beneficiaries. As recent experience with COVID-19 has shown, offering beneficiaries the opportunity to engage with their health care providers without risking viral exposure may help slow the spread of disease.

BMA supports expanding telehealth benefits in federal programs, including in Medicare Advantage as a way to improve access to care for beneficiaries with limited access to providers, e.g., those who are homebound, lack transportation, are unable to drive, and/or live in rural counties. In addition to shifting treatment to lower-cost sites of care and reducing potential time and distance barriers, telehealth can also improve access to specialists, particularly in rural areas, where few may be available. Though telehealth offerings and patient education about telehealth are currently limited, the benefit shows promise for improving health outcomes and increasing care efficiency for a range of beneficiaries.

Recent polls have found that approximately half of people over age 65 are willing to try telehealth, and that number could increase as older adults become more accustomed to technology-driven services.[9,10] Studies also show that the 65-and-older age group may be even more likely than younger demographics to try telehealth for prescription refills, chronic disease management, follow-up from inpatient procedures, and unexpected illness while traveling.[11] Increased use of telehealth during the COVID-19 crisis will likely improve understanding and acceptance of telehealth by providers and patients, and creates an opportunity to build on lessons learned from this crisis to improve care delivery going forward.

As CMS considers this and other telehealth policy options, we encourage CMS to ensure that Medicare Advantage plans can apply telehealth to all benefits available under Part B, in addition to broad categories of clinically appropriate telehealth services annually designated by the HHS Secretary. We also ask CMS to permit Medicare Advantage plans to test innovative telehealth services that reduce costs or improve outcomes (while ensuring beneficiaries have the option of receiving care in-person). Finally, we ask CMS to review existing regulations which require clinicians to be licensed in the state in which the patient being treated is located. Therefore, telehealth programs operating across state lines must adhere to onerous state-level physician and nurse regulations.[12] Telehealth rules should allow for Medicare-enrolled physicians licensed in another state to provide appropriate services, and we encourage CMS to finalize the waivers in place to support telehealth during the COVID-19 pandemic permanently to allow for expanded access to telehealth services moving forward.

- **Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System, Measure Weights (§§ 422.166(e), 423,186(e))**

BMA asks CMS not to increase the weight of patient experience/complaint and access measures or trim outliers until the serious methodological concerns with the calculation of these measures are resolved or replaced with a better methodology.

CMS proposes to increase the weight of patient experience/complaint and access measures from two to four to emphasize the importance of these issues and intends to further increase the weight of patient experience/complaints and access measures in the future. CMS also proposes to modify the clustering methodology for non-CAHPS measures by using one of two potential methods to exclude outliers.

BMA Comments:

Medicare Advantage demonstrates high-quality performance with 81 percent of beneficiaries enrolled in a high-performance plan. BMA, with our 460,000 beneficiary advocates, agrees that patient experience measures can offer important insights into consumer satisfaction with their Medicare Advantage plan. However, critical concerns about the accuracy and usefulness of the current methodologies used to assess consumer experience remain. As recently as the 2021 Advanced Notice, CMS acknowledged concerns about the ability of women to accurately recall their DXA screening history and the validity of the measure, leading them to retire the measure for measurement year 2020. BMA encourages CMS not to increase the weight of very similar measures until the serious methodological concerns with the calculation of these measures are resolved or replaced with a better methodology. We have previously called on CMS to update Star Ratings measures and their relationship to the goal of assessing quality and

[9] https://www.americanwell.com/resources/telehealth-index-2019-senior-consumer-survey/
[10] https://deepblue.lib.umich.edu/bitstream/handle/2027.42/151376/NPHA_Telehealth-Report-FINAL-093019.pdf?sequence=4&isAllowed=y
[11] Ibid at 3 and 4
[12] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0

driving improvements in health outcomes. As we have suggested, such an update could include establishing prospective thresholds for 4-Star or higher ratings in order to further drive quality improvement, reviewing the validity of consumer experience measures, eliminating compliance measures that do not relate to quality, and enhancing outcomes measures to reflect health status as well as utilization.

In addition, as discussed in other parts of this letter, BMA has concerns that patient experience measures are particularly difficult to both measure and calibrate during a pandemic. Survey tools are limited if not eliminated, and patient experience data during this period may not be particularly accurate or useful as a measure of overall performance of Medicare Advantage or individual plans. In addition, in-person access to providers is extremely limited outside essential or emergent care, and many Medicare Advantage beneficiaries may not be able to visit providers, except through telehealth, therefore they will be less able to assess their experience with in-person encounters.

BMA also opposes both CMS proposals regarding outliers: trimming all scores above the 99th and below the 1st percentiles prior to clustering, and using the Tukey outer fence outlier deletion tool. We are concerned that CMS is unable to accurately model the combined impact on the Medicare Advantage program of both increasing the weight of patient experience measures and trimming outlier scores.

BMA asks CMS to consider whether the Consumer Assessment of Healthcare Providers and System (CAHPS) surveys are the best tool to measure patient satisfaction and to explore alternatives and/or improvements to CAHPS. Assessment of consumer experience is important, yet CAHPS measures have proven to be highly variable, unreliable, lacking in demonstrated clinical relevance, and do not provide meaningful information for Medicare Advantage plans to improve quality. While CAHPS measures are intended to provide consumers with meaningful information to use in comparing Medicare Advantage and Part D plans, they are, at present, not meeting this goal. The intricate CAHPS Star Ratings adjustments amplify challenges including plans' restricted access to data and tightening cut-points, which substantially minimizes the objectivity and meaningfulness of CAHPS measures. In addition, adjustments made to CAHPS scores to improve significance and reliability consistently skew quality improvement insights, diminishing the value of the survey.

BMA is engaged in research regarding the Star Ratings System. Specifically, BMA has plans to explore changes and improvements to the Star Ratings System regarding consumer experience measures including the accuracy of measures that rely on survey data, provision of usable data to beneficiaries, and ensuring that measures meet the goals of delivering high-quality care and supporting the move to value-based care. We are happy to share these findings to CMS when they are available and look forward to engaging with you on this issue.

- **Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System, Extreme and Uncontrollable Circumstances (§§ 422.166(i), 423.186(i))**

BMA asks CMS to align its policies on disasters and catastrophic events across Medicare Advantage, to lower the threshold of beneficiaries impacted by a disaster required to qualify for Star Ratings accommodations to 20 percent, and to take a more holistic view of the impact of separate disasters on a plan's beneficiaries. We appreciate that CMS has taken action to waive or modify Star Ratings to address the significant disruption COVID-19 is causing in plans' ability to provide and manage the types of services that are foundational to the Star Ratings System and in doing so, have acknowledged there may be further modifications needed.

The current rule for treatment of multiple year-affected contracts was established to limit the age of data that will be carried forward into the Star Ratings. CMS uses the measure score associated with the year with the higher measure Star Rating regardless of whether the score is higher or lower that year. CMS finalized this policy to address when contracts are affected by separate extreme and uncontrollable circumstances that occur in successive years for the adjustments to CAHPS, Health Outcomes Survey (HOS), HEDIS, and other measures. CMS solicits comments on this policy and whether further adjustments are necessary.

BMA Comments:

BMA notes that CMS uses different standards to trigger different accommodations in response to extreme and uncontrollable circumstances. We appreciate that CMS has used its authority to address issues in Medicare Advantage during the COVID-19 emergency. We ask that CMS align its policies on disasters and catastrophic events to clarify the inclusion of Medicare Advantage in the future. Such alignment should ensure that any type of federal disaster declaration triggers the flexibility and accommodations available to beneficiaries and plans. CMS currently uses different thresholds to trigger a waiver of benefit limitations and special enrollment periods that are available to Medicare Advantage beneficiaries in the event of an emergency or disaster declaration. CMS uses a third standard to determine when Medicare Advantage plans qualify for adjustments to their Star Ratings calculation following an extreme or uncontrollable circumstance. Aligning the accommodations available to beneficiaries and plans due to extreme or uncontrollable circumstances will provide a more seamless application of CMS' policies across the program, enabling plans to better assist beneficiaries and ensure plans are appropriately measured on their performance during and after emergencies and disasters.

BMA encourages CMS to permit these accommodations when any federal disaster or emergency is declared. We note that the current extreme and uncontrollable circumstances policy in the Star Ratings program is limited to Individual Assistance disaster declarations made by the Federal Emergency Management Agency (FEMA). While we appreciate that the intent of this policy is to target Star Ratings adjustments to areas where services provided to beneficiaries may be impacted, we believe the current policy is too limited and does not appropriately consider the circumstances that beneficiaries and plans face under other types of FEMA disaster and emergency declarations. In 2019, for example, beneficiaries living in many California counties suffered from wildfires, but, under the current policy, the Medicare Advantage plans serving them are ineligible for Star Ratings adjustments because of the type of disaster declaration FEMA used. This is despite the fact that several California counties qualified for the adjustments due to wildfires during the two previous years.

Second, BMA asks CMS to consider lowering the threshold of beneficiaries impacted by a disaster required to qualify for Star Ratings accommodations from 25 percent to 20 percent. Currently, at least 25 percent of a plan's beneficiaries must reside in a FEMA-designated Individual Assistance area in order for the plan to qualify for Star Ratings adjustments. We believe this threshold is unnecessarily high and that 20 percent is a more appropriate threshold for Star Ratings adjustments. When 20 percent of a plan's beneficiaries are affected by natural disaster, it can substantially impact a plan's Star Rating performance.

Third, BMA asks CMS to consider a more holistic view of how multiple disasters may impact a plan's beneficiaries and Star Rating, particularly for plans that provide coverage to beneficiaries in multiple states, and to offer clarification of its application of this policy in such a circumstance. On its own, one disaster may not affect the required percentage of beneficiaries to trigger Star Ratings adjustments. However, multiple disasters across several states may, in aggregate, reach the threshold and should be considered together. This may be especially true for EGWPs that serve retirees living in many different states. BMA also asks CMS to consider when a single disaster spans multiple years, for example when a disaster or public health emergency has a long duration, happens at the end of a year, or when the disaster

has been declared after the event occurred. We urge CMS to clarify application of this policy and take a holistic view as it considers the effect of different extreme and uncontrollable circumstances on beneficiaries and Medicare Advantage plans.

Finally, we thank CMS for the modifications that have already occurred in the Star Ratings System, and ask that should additional modifications be made to the extreme and uncontrollable circumstances policy that consideration be given to hold harmless provisions, such as prescription drug recalls and prescription drug shortages, similar to those caused by COVID-19, which resulted from disruptions to the prescription drug supply chain. While plans are taking steps to address these recalls and shortages, we ask that CMS issue guidance to provide certainty as to how CMS intends to take into account this national emergency for Star Ratings and Quality Bonus Payments.

- **Maximum Allowable Cost Sharing and Two Specialty Tiers in Part D**

BMA supports CMS' proposal allowing Part D plans to maintain two specialty tiers, as well as its specific proposals on maximum allowable cost sharing amounts.

CMS proposes that a Part D plan may maintain up to two specialty tiers. Further, CMS proposes to set a maximum allowable cost sharing for a single specialty tier, or, in the case of a plan with two specialty tiers, the higher cost-sharing, specialty tier, of: (1) 25 percent coinsurance for plans with the full deductible provided under the Defined Standard benefit; (2) 33 percent coinsurance for plans with no deductible; and (3) for plans with a deductible that is greater than $0 and less than the deductible provided under the Defined Standard benefit, a coinsurance percentage that is between 25 and 33 percent, determined by subtracting the plan's deductible from 33 percent of the initial coverage limit (ICL), dividing this difference by the difference between the ICL and the plan's deductible, then rounding to the nearest one percent. CMS solicits comment on this approach.

BMA Comments:

BMA supports the CMS proposal allowing plans to maintain two specialty tiers, as well as its specific proposals on maximum allowable cost sharing amounts. This is an important improvement to benefit design flexibility, allowing plans to best tailor benefits and services to the needs of beneficiaries. As CMS is well aware, drug costs can differ by thousands of dollars, making a single tier inappropriate and insufficient. A single tier can even encourage beneficiaries to go through the exception process for a non-formulary drug, if that copay is lower than cost sharing for the covered drug.

With this change, we also reiterate our belief that it is vital for Medicare beneficiaries to understand the array of coverage offerings and associated cost sharing obligations for different plans, as they make plan choices. With this change, CMS must continue to improve written and online materials to provide clear, unbiased, user-friendly language and graphics, and engage in public campaigns to inform and educate beneficiaries and their caregivers about cost sharing obligations and other plan options.

- **Beneficiary Real Time Benefit Tool (RTBT) (§ 423.128)**

BMA supports the proposed requirement to implement beneficiary RTBTs. Empowering patients with real-time cost-sharing information, including lower-cost alternatives, is a priority for Medicare Advantage plans.

CMS proposes to require Part D plan sponsors to implement beneficiary RTBTs beginning on January 1, 2022. These tools would be required to display real-time patient cost-sharing values as well as information on lower-cost therapeutic alternatives, including formulary coverage, tier placement, and any utilization management requirements. Plans are encouraged, but not required, to include the plan's negotiated price in the tool. To encourage beneficiaries to use the beneficiary RTBT, CMS proposes to allow plans to offer rewards and incentives to their beneficiaries who use the tool.

BMA Comments:

BMA supports the proposed requirement to implement beneficiary RTBTs. Empowering patients with real-time cost-sharing information, including lower-cost alternatives, is a priority for Medicare Advantage Prescription Drug (MA-PD) plans. Most MA-PD plans have this tool in place today through their own member portals, and we encourage universal implementation. In addition, we support the proposal to allow plans to offer rewards and incentives to beneficiaries who use the tool. The subsequent section below ("Rewards and Incentives Program Regulations for Part C Beneficiaries") outlines our comprehensive recommendations on improving the Rewards and Incentives Program overall. The recommendations below - for expanded flexibility to facilitate greater engagement and contribute to improved overall health outcomes – apply here as well.

Codifying Existing Part C and Part D Program Policy

- **Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services (§§ 422.100 and 422.101)**

BMA does not support CMS' proposal to increase the MOOP for all Medicare Advantage beneficiaries by incorporating out-of-pocket costs incurred by individuals with ESRD. Instead, BMA urges CMS to increase ESRD benchmarks to account for the higher costs of beneficiaries with ESRD.

For CY 2022, CMS proposes to establish up to three MOOPs, including the current mandatory and voluntary MOOP limits, and adding a third, intermediate MOOP limit. Additionally, CMS proposes a multiyear transition to incorporate ESRD costs into a methodology for setting MOOP limits, beginning in 2021.

BMA Comments:

BMA appreciates CMS' understanding that current ESRD reimbursement will not cover the high costs of ESRD beneficiaries in Medicare Advantage, and could lead to increases in plan costs and beneficiary cost sharing and/or premiums. However, we do not agree with CMS' proposed solution of increasing the maximum out-of-pocket (MOOP) limit for all beneficiaries by incorporating costs incurred by beneficiaries with ESRD into the MOOP calculation. While some increase in the MOOP may be justified, the current proposal simply raises costs for all beneficiaries. It functionally asks non-ESRD beneficiaries to shoulder the financial burden of adding ESRD beneficiaries to the risk pool.

Instead, to ensure adequacy of payments, CMS should increase ESRD benchmarks by accounting for the MOOP limit in their calculation. This will protect all beneficiaries from high out-of-pocket spending. If the benchmark does not account for the MOOP limit, all beneficiaries (ESRD and non-ESRD alike) will bear a greater cost burden.

- **Medicare Advantage and Cost Plan Network Adequacy (§§ 417.416 and 422.116)**

BMA supports CMS' proposed changes to network adequacy standards and recommends CMS finalize the network adequacy policy updates as soon as possible to allow Medicare Advantage plans to incorporate this change into their CY 2021 bids. In addition, we recommend that CMS provide the 10 percent credit toward time and distance standards for plans that contract with nephrologists for telehealth services, in addition to the other providers CMS includes in its proposal.

CMS proposes a 10-percentage-point credit towards the percentage of beneficiaries residing within the applicable time and distance standards when the plan contracts with certain provider specialty types for telehealth services and for plans in states with Certificate of Need laws or other restrictions on the number of providers. CMS solicits comments on whether nephrology should be added to the list and whether the size of the credit should vary by county type.

CMS also proposes to reduce the percentage of beneficiaries residing in a Micro county, Rural county, or County with Extreme Access Considerations (CEAC) who have access to at least one provider/facility of each specialty type within the published time and distance standards from 90 percent to 85 percent.

CMS solicits comments on network adequacy standards related to dialysis: 1) whether it should remove outpatient dialysis from the list of facility types for which Medicare Advantage plans need to meet time and distance standards; 2) allowing plans to attest to providing medically necessary dialysis services in its contract application (as is current practice for durable medical equipment (DME) and other items/services) instead of requiring plans to meet time and distance standards; 3) allowing exceptions to time and distance standards if a plan is instead covering home dialysis for all beneficiaries who need these services; and 4) customizing time and distance standards for all dialysis facilities.

BMA Comments:

BMA supports CMS' proposed changes to network adequacy standards and we recommend CMS finalize the network adequacy policy updates as soon as possible to allow Medicare Advantage plans to incorporate the changes into their CY 2021 bids. Overall, we encourage CMS to continue its focus on expanding beneficiary access to additional providers.

BMA encourages CMS to expand the proposed 10 percent credit towards the percentage of beneficiaries residing within published time and distance standards to include telehealth nephrologists, in addition to other proposed specialists. Expanding the credit to include nephrologists may assist plans and providers in ensuring access to care and services for beneficiaries with chronic kidney disease (CKD) and ESRD. We also support CMS' proposal to modify network adequacy standards by lowering the percentage of beneficiaries that must reside within the maximum time and distance standards in Micro, Rural, and CEAC counties. Additionally, we support the proposal for Medicare Advantage plans to attest to providing dialysis as part of their application and support other ways to modify network requirements that could increase access to a diversity of outpatient facilities, such as hospital outpatient dialysis units.

BMA agrees that revisions to telehealth and maximum time and distance standards will improve access to Medicare Advantage plans for those in rural and underserved areas. This, in turn, will encourage the use of telehealth services that can better ensure access to services and continuity of care for beneficiaries, especially in rural areas. BMA has long called on CMS to accommodate innovative care delivery models by allowing telehealth and mobile providers to count towards network adequacy, especially for rural areas. In addition, as referenced previously, we encourage CMS to expand use of telehealth for all beneficiaries to increase access, for convenience and reduction in travel time, address lack of access to transportation, and relieve stress for beneficiaries, including those with ERSD. We strongly support CMS' proposal to reduce the proportion of beneficiaries who must meet time and distance standards in

Rural, Micro, and CEAC counties, and we believe this may help expand Medicare Advantage options to more Americans.

BMA supports and encourages the innovation in treatment for ESRD beneficiaries that may result from these changes, including the increased utilization of home dialysis, mobile dialysis units, and other innovative means of delivering care. We ask CMS to consider changes to Medicare Advantage network adequacy requirements for dialysis providers. The dialysis provider market is highly concentrated, largely dominated by two provider organizations. Because Medicare Advantage plans must meet network adequacy requirements, they have few options to leverage price competition in most markets, driving Medicare Advantage payments to ESRD providers significantly higher than Traditional FFS Medicare rates. However, because the ESRD benchmarks are based on Traditional FFS Medicare payment rates, they underrepresent the true cost of care in Medicare Advantage. CMS should consider changes to network adequacy requirements or other tools that would allow Medicare Advantage plans to leverage market forces while ensuring beneficiaries have access to dialysis services.

We believe several of the policy proposals on which CMS requests comments would help to alleviate these challenges. As indicated in other sections, BMA supports CMS' proposed changes with regard to dialysis provider network adequacy standards. We also support removal of outpatient dialysis from Medicare Advantage plan time and distance standards, as well as allowing plans to attest to providing medically necessary dialysis services in the contract application (as plans currently do for DME and other items and services). In addition, we believe providing exceptions to time and distances standards for plans covering home dialysis for all beneficiaries who need such services and customizing time and distance standards for dialysis facilities would allow plans to find innovative ways to ensure access to dialysis care for all beneficiaries with ESRD.

BMA believes these changes will help support innovations in care, including the use of telemedicine for routine dialysis-related check-ups, advances in home dialysis, and strides in other treatment modalities. Advances in dialysis now allow individuals with ESRD to receive treatment at home, improving independence and convenience.[13] Some home hemodialysis and home peritoneal dialysis treatments involve nocturnal dialysis or shorter, more frequent sessions than the three times per week model typical of in-center dialysis. We encourage CMS to enact policies that support these dialysis innovations. We also support the goal of the Administration's 'Advancing American Kidney Health' initiative, which seeks to have 80 percent of new ESRD patients receive a transplant or home dialysis by 2025.

In addition, we ask CMS to consider changes to conditions of coverage for ESRD facilities to allow for the provision of dialysis in additional settings. It is very difficult, and in some cases impossible, for innovative dialysis provider types to meet existing conditions of coverage, which were designed for the provision of dialysis in a large clinic setting. We stand ready to collaborate with CMS to update these regulations to outline conditions of coverage specific to micro dialysis clinics, home dialysis training and support facilities, and mobile dialysis facilities. In order to encourage these types of providers to serve Medicare beneficiaries, CMS should outline general requirements as well as requirements for infection control, isolation rooms, physical environment, patient plan of care, care at home, personnel qualifications, and governance that recognize the unique services these providers offer.

Finally, as CMS continues to consider changes to network adequacy requirements, we encourage CMS to consider providing greater flexibility for EGWPs to serve rural beneficiaries, which are currently constrained by the limitation that EGWPs can only serve an employer if there is a direct contracting

[13] https://www.bettermedicarealliance.org/sites/default/files/2020-01/BMA_WhitePaper_CaringForESRDBeneficiaries-FIN_0.pdf

provider network available to at least 51 percent of the employer group's retirees. Implementing additional flexibilities for provider network requirements could address factors that inhibit the formation of direct contract networks and enable more EGWPs to serve rural markets.

- **Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)**

BMA encourages CMS to provide expanded flexibility for plans to improve engagement and care coordination and to allow plans to use beneficiary incentives.

CMS proposes to require rewards and incentive (R&I) programs to be uniformly offered to any qualifying individual, defined as any plan beneficiary who qualifies for the coverage of the benefit and meets criteria for participating in a reward program. CMS is also proposing to require that a Medicare Advantage plan provide accommodations for members who are eligible for rewards but unable to participate in the rewards program, and that R&I programs cannot use certain health measurements as metrics for program success (e.g., weight lost).

BMA Comments

BMA encourages CMS to provide expanded flexibility to use beneficiary incentives that improve engagement and care coordination and to allow plans to use beneficiary incentives. In some circumstances, patient engagement and participation may be enhanced by incentives that provide extra motivation for beneficiaries to be active participants in their care. CMS recognizes this and, in the Medicare Managed Care Manual, provides guidance for the provision of rewards and incentives "to encourage beneficiaries to be actively engaged in their health care and, ultimately, improve and sustain their overall health and wellbeing."[14] Recent legislative and regulatory activities have permitted Medicare Advantage plans to tailor health benefits to targeted populations, ensuring they meet the unique needs of specified groups of beneficiaries based on diagnosed conditions or diseases. In the same way, CMS should explore permitting Medicare Advantage plans to tailor rewards and incentive programs for beneficiaries to meet the needs of clearly defined groups of beneficiaries. This can improve participation in care and improve outcomes by incentivizing compliance in clinical recommendations such as attending office visits, filling prescriptions, or participating in wellness programs tailored to their needs. BMA asks CMS to provide expanded flexibility for Medicare Advantage plans in utilizing beneficiary incentives.

Some ways to provide flexibility in the provision of rewards and incentives that will facilitate greater engagement and contribute to improved health outcomes for Medicare Advantage beneficiaries include:[15]

- Incentive programs customized and targeted to beneficiaries' clinical status, to higher-need beneficiaries who would most benefit from the incentivized intervention, or to beneficiaries not using the benefit;
- Enhanced flexibility to define the amount of the reward or incentive, such as in cases where the benefit utilized may be a low-cost but high-value intervention in terms of beneficiary health or care utilization improvement;
- Provision of the entire incentive upfront, rather than after the incentivized benefit has been utilized, to capitalize on humans' innate tendency toward loss aversion;

[14] Centers for Medicare & Medicaid Services, "Medicare Managed Care Manual." Chapter 4 – Benefits and Beneficiary Protections. 22 Apr 2016. Web.
[15] https://www.bettermedicarealliance.org/policy-research/resource-library/encouraging-healthy-behaviors-expanding-beneficiary-rewards

- Provision of incentives in the form of monetary credits toward monthly premiums or cost sharing requirements;
- Expansion of beneficiary incentives to MA-PD plans to, for example, offer incentives for prescription drug adherence targeted to defined populations of beneficiaries;
- Allowing electronic communications to educate, inform, and encourage beneficiaries on use of services that may be low-cost, but impact subsequent higher administrative or service costs;
- Allowing plans to offer rewards and incentives that may surpass the value of the health service or activity, and allowing incentives for low-cost, high-value services, such as flu shots; and
- Allowing plans to offer financial rewards for participation in evidence- based health programs or achievement of health goals.

BMA welcomes an opportunity to work with CMS to revise rewards and incentives regulations to provide even greater improvement in beneficiary engagement and care coordination.

- **Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62 and 423.38)**

BMA commends CMS on its proposal to offer a special election period to beneficiaries enrolled in plans that experience significant financial hardships or quality performance issues. We also strongly encourage CMS to expand the SEP for individuals affected by a FEMA-declared, weather-related emergency or major disaster to include public health emergencies such as the COVID-19 pandemic.

CMS proposes to codify the majority of SEPs and add two new SEPs. The first is a SEP for Individuals Enrolled in a Plan Placed in Receivership; such individuals may disenroll from the Medicare Advantage plan and switch to a different plan or Traditional FFS Medicare. The second is an SEP for Individuals Enrolled in a Plan Identified as a Poor Performer; such individuals may disenroll. CMS also seeks specific comment as to whether it has overlooked any feature of the current policy that should be codified and if there are other exceptional circumstances not identified for which CMS should consider establishing a special election period.

BMA Comments:

BMA commends CMS on its proposal to offer a special enrollment period to beneficiaries enrolled in plans that experience significant financial hardships or quality performance issues. Such financial and performance issues can measurably impact a beneficiary's experience, including their ability to receive quality health care services or have their claims paid on time. We support offering beneficiaries the flexibility to switch plans in these exceptional circumstances.

CMS also seeks comment on exceptional circumstances not identified that are worthy of establishing a special election period. We strongly encourage CMS to expand the SEP for individuals affected by a FEMA-declared, weather-related emergency or major disaster to include public health emergencies such as the COVID-19 pandemic, and to align such SEPs with the extreme and uncontrollable circumstances policy. Individuals in areas of the country seriously affected by the pandemic may be unable to make careful, informed decisions about plans, or they simply may need to make such decisions outside of the usual timeframe.