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Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Coverage Year (CY) 2024 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) Model Documents (2023-09053; CMS-10260)

Lumeris appreciates the opportunity to respond to the Centers for Medicare & Medicaid Service’s (CMS) proposed changes for the Coverage Year (CY) 2024 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) Model Documents. Lumeris supports CMS’ strategic vision and its core principles of person-centered care through its operation of Essence Healthcare’s plans and as a leader in value-based care solutions for provider systems. Essence originated as a purposely built provider-aligned Medicare Advantage (MA) plan with the aim of producing the industry's highest quality clinical outcomes and highest rated consumer satisfaction while driving market leading reductions of inpatient utilization and overall medical costs. As an organization, Lumeris is dedicated to the idea that radical change in health outcomes and performance occurs by placing patients at the center of care and decisioning, support by committed provider, payers, and technologies moving synergistically toward the goal of improving and maintaining a patient’s health. Our commitment to our Essence members is the same – high quality care can be accessible and affordable to all beneficiaries when supported by value-based agreements that drive both quality outcome measures and cost management.

We welcome the agency’s openness to stakeholder input and ongoing commitment to enhancing the model materials utilized by MA organizations. It is essential that we continue to strive to create benefit materials focused on readability and understandability for the Medicare-eligible populations we serve. Below is feedback from Lumeris team members and key stakeholders regarding the proposed model documents related to our HMO and PPO lines of business.

HMO and PPO MAPD EOC, Chapter 4, Medical Benefits Chart, Colorectal Cancer Screening

The updated language for Colorectal Cancer Screening specifically mentions that the Part B deductible does not apply; however, other preventive services where the Part B deductible does not apply under Original Medicare does not contain the same note. We would recommend removing this reference to the Part B deductible to reduce enrollee confusion since the model language states at the beginning of the benefit description that “There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies.”

HMO and PPO MAPD EOC, Chapter 6, Section 1.1

In reviewing the second paragraph of this section related to the “Real Time Benefit Tool,” we noticed a reference to Chapter 3, Section 3, which addresses how to get services when there is an emergent or urgent need for care during a disaster. We believe that this reference may have been made in error and should reference an alternative section of the EOC.

HMO MAPD EOC, Chapter 7, Section 1

In reviewing the crosswalk for the EOC, we noted that the text “outside the service area” was noted as having been deleted from the first sub-bullet discussing emergent or urgent medical care provided from out of network providers in this section; however, the text appears to have not been removed from the model document. We encourage CMS to review the crosswalk and model EOC and provide clarity on this discrepancy.

HMO and PPO MAPD EOC, Chapter 9, Section 4.1

We recommend that CMS provide clarification around the statement in Section 4.1 related to what constitutes a coverage decision that reads, “For example, **if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision** unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition.” Under Chapter 4 of the Medicare Managed Care Manual, enrollees may not be held financially liable for plan-directed care (such as a referral from a network physician to an out-of-network medical specialist); however, the act of physician plan direction does not constitute a favorable organization determination under current regulatory or sub-regulatory guidance. We recommend that CMS ensure this distinction is appropriately accounted for in the finalized models.

HMO and PPO MAPD EOC, Chapter 9, Section 4.1

We recommend that CMS consider reorganizing the bullet points in the 4th paragraph of this section which discusses the appeals process to mitigate the potential for enrollee confusion between the processes for Part B and Part D drugs. We noted a few references to the Level 2 appeals process were not pointing to the appropriate sections in the model. We believe the reference to Part B drug Level 2 appeals should point to section 5.4 since section 6.4 is specific to Part D drug appeals. We believe the reference for Part D drug Level 2 appeals should point to Section 6 since Section 7 in the model documents point to the process for discharge too soon concerns in inpatient hospital stays. We would recommend that CMS reformat that excerpt in the following manner:

If we say no to all or part of your Level 1 appeal for medical services and Part B drugs, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical services and Part B drugs to Level 2 if we do not fully agree with your Level 1 appeal. See Section 5.4 of this chapter for more information about Level 2 appeals.

For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.