UPMC LIFE CHANGING MEDICINE

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Re: CMS-2017-0163: "Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter" and "Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model"

UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division (collectively, "UPMC") are pleased to submit the following comments in response to the Centers for Medicare & Medicaid Services (CMS or the "Agency") 2019 Advance Notice Parts I and II and draft Call Letter, as published on December 27, 2017 (Part I) and February 1, 2018 (Part II and draft Call Letter), collectively referred to herein as the "Letter."

UPMC is pleased to offer a full range of commercial individual and group health insurance, Medicare Advantage (MA), Medicare Special Needs Plans (SNPs), CHIP, Medicaid, behavioral health, dental, vision, employee assistance and workers' compensation coverage products. Our MA Plan, UPMC *for Life*, serves approximately 160,000 members combined through the MA Part C/D and SNP programs; more than 21,000 of these members are enrolled in UPMC *for Life* Dual, the largest stand-alone 4-star D-SNP in the nation. Through our Medicaid managed care organization, UPMC *for You*, we provide coverage to more than 400,000 enrollees across 40 Pennsylvania counties, and our behavioral health managed care organization, Community Care Behavioral Health, manages mental health and substance abuse services for almost one million Medical Assistance enrollees in Pennsylvania. UPMC also recently began enrolling members through Pennsylvania's Community HealthChoices, a Managed Long-Term Services and Supports (MLTSS) program that is expected to serve more than 360,000 individuals who are disabled, placed in nursing homes, or dually eligible for Medicare and Medicaid. Collectively, our commercial and government programs membership exceeds 3 million.

We thank CMS for affording Medicare Advantage Organizations (MAOs) and other stakeholders an opportunity to comment on anticipated future changes to the MA and Part D program(s). UPMC supports CMS in its ongoing efforts to improve the quality, integrity, and efficiency of the Medicare program for all beneficiaries, while also ensuring that Medicare payment policies and administrative requirements continue to support the innovation and quality improvement long advanced by MAOs. It is with this support in mind that we respectfully offer for your consideration the following comments.

Part I: CMS-HCC Risk Adjustment Model

Additional Diagnosis Codes: Substance Use Disorders

The Letter proposes to add new Substance Use Disorder (SUD) diagnosis codes to better reflect ICD-10 diagnosis code classification(s). While we agree that the use of diagnosis codes with greater SUD-related specificity should support greater overall accuracy in the Risk Adjustment (RA) Model, we are concerned that the proposed expansion of SUD codes in the Model fails to account for State-specific barriers to the ongoing collection of SUD-related medical records. While many States may conform to federal privacy standards for the protection and disclosure of mental health and/or SUD diagnosis and treatment information, Pennsylvania imposes additional protective limits on disclosure of such records, particularly with respect to SUD. Because MAOs and providers in Pennsylvania are accustomed to operating within the limits of our Commonwealth's additional legal protections for SUD patients, the collection of complete information to support SUD coding even within the current Model is challenging; the addition of more, and more specific, diagnosis codes is likely to make this task even more difficult. The disclosure limitations in Pennsylvania, and any other States that impose additional privacy restrictions on SUD-related records, will constrain the ability of MAOs to collect and adequately substantiate SUD diagnoses within the HCC reporting structure. This will in turn result in artificially low RA scoring for plans in Pennsylvania, and will impair the comparability and utility of global RA Model data. We respectfully urge CMS to withdraw the proposed additional SUD diagnosis codes at this time, and to engage State regulators in efforts to ensure that any disclosure requirements can be appropriately met in the context of otherwise applicable State protections for such data.

Payment Condition Count (PCC) Model

The Letter proposes to implement a new "Payment Condition Count (PCC) Model" for 2019, and notes the Agency's analysis that this model would raise *overall* risk scores by 1.1% compared to the current RA Model. While we support the Agency's efforts to identify a viable alternative RA methodology that supports increased scoring accuracy, we urge caution in extrapolating viability or accuracy based on a single, overall impact score. A recent Oliver Wyman analysis of the PCC Model reflects an almost identical overall impact, but also illustrates that, when compared to current methodology, the PCC

Model generally increases risk scores for healthy individuals with no conditions while *decreasing* risk scores for those with 1, 2, or 3 conditions; in some cases, an individual with 3 conditions would be assigned a risk score that is a full 5 percent lower than another individual from the same cohort but with no reported conditions.[1] Notably, some of the largest score reductions under the PCC Model would be assigned to full and partial dual eligible individuals with 2 or 3 reported conditions. This type of result not only fails to achieve the goal of more accurately accounting for the increased costs of individuals with multiple conditions; it also imposes disproportionate negative adjustments to risk scores for those individuals who are more likely than their peers to *have* multiple reportable conditions. Based on these projected outcomes, we respectfully ask that the Agency withdraw its proposed adoption of the PCC Model for 2019. We encourage the Agency to use the 2019 Final Call Letter to identify other models under consideration and solicit feedback from stakeholders regarding the relative impact and merit of the same.

All Condition Count (ACC) Model

The Letter states the Agency's assessment that, overall, the alternatively proposed "All Condition Count (ACC) Model" would reduce, rather than improve, the accuracy of the RA program. We agree with this assessment, and are particularly concerned about the degree of variability in ACC-generated risk scores across plans. Any change to the current RA methodology should improve the program's accuracy and reliability, and support relative comparisons between plans on a level playing field; we do not believe that the ACC Model achieves either of these objectives. We respectfully recommend that the Agency refrain from implementing the ACC Model in the Risk Adjustment program.

Part II: Changes in the Part C Payment Methodology for CY 2019

Section G - MA Employer Group Waiver Plans

In finalizing the transition to the 2017 "bid-to-benchmark" (B2B) ratio for Employer Group Waiver Plans (EGWPs), the Letter asks whether the Agency should: (i) include an additional adjustment to reflect the proportion of beneficiaries enrolled in HMO vs. PPO as between EGWPs and individual market plans, and (ii) maintain a 50/50 blend between individual market plan bids and EGWP bids. EGWPs represent an important and valuable retiree support resource that is often part of a broader retirement benefit package; many retirees understandably rely on these benefit packages for purposes of post-employment financial planning. We support the Agency's desire to ensure that EGWP payments under the MA program are appropriately balanced with individual market plan payments, but are concerned that full implementation of the 2017 B2B

[1] Giese, Glenn, Sober, Josh, Fitzpatrick, Randall. 2019 Advance Notice: Changes to Medicare Advantage payment methodology and the potential effect on Medicare Advantage organizations. Oliver Wyman. February 2018.

methodology would force employers to materially reduce benefits or increase retiree premiums for 2019. While some reduction to EGWP payments, and therefore benefits, may be driven by appropriate plan payment adjustments in the long-term, significant single year reductions and/or those prompted by methodological inaccuracies are not aligned with the MA program's goal of consistently serving and protecting beneficiaries. As such, we support both of the Agency's proposed B2B ratio adjustments for EGWPs in 2019, and further respectfully recommend that the Agency maintain the proposed 50/50 bid blend until the beneficiary impact of the new B2B methodology can be fully evaluated.

Part II: Draft Call Letter

Section I – Parts C and D

Enhancements to the 2019 Star Ratings and Future Measurement Concepts: Proposed Scaled Reductions for Appeals IRE Data Completeness Issues (p.114)

Under the current Star Ratings methodology for appeals, plans that closely monitor their caseloads and send all late cases to the IRE are likely to receive lower measure scores than plans who may be less stringent in their oversight; such a result runs counter to the underlying intention of the Star Ratings program. We support the Letter's proposed use of the Timeliness Monitoring Project (TMP) to identify data integrity issues in IRE data used for appeals-related measures. In considering the implications of this proposal, we have identified the following areas in which we believe clarity from the Agency would be helpful to plans as they seek to incorporate associated monitoring and reporting functions for 2019:

(i) Reopened Cases. While reopened cases are included in plans' universe files, it is unclear whether these cases are treated differently when timeliness is calculated under TMP guidelines.

(ii) Standard to Expedited Requests. If a coverage determination request is originally submitted as Standard but then, after the 24-hour timeframe has passed, is requested by a member or prescriber to receive Expedited treatment, a plan may grant the request. In doing so, however, the current universe reporting schema means that such a request could be categorically considered to be untimely. It is unclear whether the TMP will take this scenario into consideration when calculating timeliness for Expedited requests.

(iii) Approvals within 24 Hours of Expiration. Under current CMS guidance, requests that are approved within 24 hours of expiration are not sent to the IRE. It is unclear, however, whether the TMP would mark such cases as untimely based on otherwise applicable timeliness standards.

Plan Finder Civil Money Penalty (CMP) Icon or Other Type of Notice (p.164)

The Letter proposes to increase transparency for beneficiaries by displaying "an icon or other type of notice on Plan Finder for sponsoring organizations that have received a CMP." We support the Agency's ongoing efforts to promote transparency and information accessibility for beneficiaries in the MA program. That said, we also believe it is important that any CMP-related information displayed in the Plan Finder not mislead or confuse beneficiaries, particularly when they are making plan selections. Importantly, plans may be subject to CMPs for a host of distinct compliance issues that can vary dramatically in severity and potential beneficiary impact. It is unclear from the Letter whether the proposed icon or notice can be appropriately tailored to reflect the relative significance of CMPs between plans, and we believe it is important to exercise caution in the adoption of any new Plan Finder feature that has not been evaluated through consumer testing to ensure that it enhances and supports beneficiary decision-making. We respectfully ask that the Agency withdraw the proposed CMP icon/notice for 2019, and convene stakeholders to develop and evaluate a detailed proposal for inclusion of CMP-related information in the Plan Finder, whether through an icon or otherwise. If the Agency is nonetheless compelled to incorporate a CMP icon or notice into the Plan Finder for 2019, we respectfully recommend that it be tailored to maintain reasonable comparability between plans and to appropriately convey a range of multiple designations for CMP severity and beneficiary impact.

Audit of the Sponsoring Organization's Compliance Program Effectiveness (p.165)

The Letter asks whether CMS should allow sponsors to treat a CMS program audit as satisfying the annual Compliance Program Effectiveness (CPE) audit requirement for one year from the date of the program audit. As the Agency notes, current standards requiring sponsors to both support a program audit and concurrently conduct a CPE audit are both administratively burdensome and often duplicative. The proposed allowance will free plan resources to better support and respond to program audits, which will ultimately promote better collaboration and timeliness of related interactions between sponsors and the Agency. We strongly support the proposed allowance.

Section II – Part C

Health Related Supplemental Benefits (p.182)

The Letter proposes to expand the scope of permissible supplemental benefits that are "primarily health related," as that term is used in Section 1852(a)(3) of the Social Security Act. As described, the proposed interpretation would permit plans to offer a greater range of benefits, thereby allowing the MA program to more fully address health outcomes, quality of life, and beneficiary independence; the value of such a result for

beneficiaries cannot be overstated. We encourage the Agency to adopt its proposed interpretation in final rulemaking.

Medicare Advantage (MA) Uniformity Flexibility (p.184)

The Letter proposes to implement a limited exception to the long-standing "Uniformity Requirements" in the MA program by allowing sponsors to vary, subject to certain protections, cost sharing for certain covered benefits, available supplemental benefits, and applicable deductibles for enrollees that meet specific medical criteria. We believe that this allowance represents a welcome change for many MAOs, and that it will significantly improve the ability of plans to offer coverage and benefits that best meet the diverse needs of the most vulnerable MA beneficiaries. We also support the Agency's stated requirements regarding objective medical criteria and relationship of cost sharing reductions and benefits to a given disease condition; we agree with the Agency that these represent important protections against possible manipulation or misuse of the new exception to discourage or discriminate against certain vulnerable and higher-acuity beneficiaries. Finally, we support the Agency's intention to establish a special mailbox to handle plan questions regarding the permissibility of a targeted supplemental benefit under the new uniformity rules. We encourage the Agency to adopt the foregoing proposal for 2019 as described in the Call Letter.

Medicare Advantage (MA) Segmented Service Area Options (p.185)

The Letter affirms a prior Agency proposal that would permit MAOs to vary supplemental benefits (in addition to existing variability in premiums and cost-sharing) by service area Segment, subject to uniformity throughout any given Segment. We believe that this new flexibility will improve the ability of MAOs to design plans with targeted benefits that better serve beneficiaries' needs. These targeted supplemental benefits will help support higher quality, improved health outcomes, and a better beneficiary experience in rural counties or other areas with limited dental and vision provider concentration, or where a regional population has a higher incidence of a particular chronic disease. We respectfully encourage the Agency to include the proposed benefits flexibility by Segment in the 2019 final Call Letter.

Section III – Part D

Formulary Submissions: CY 2019 Formulary Reference File (p.193)

The Letter proposes to remove from the Part D Formulary Reference File (FRF) those drugs for which utilization under Part D would be "extremely rare." We acknowledge the Agency's assessment that the inclusion of such drugs, many of which are more commonly covered under Part B, may increase confusion for beneficiaries when reviewing Part D formularies within the Plan Finder. We also very much appreciate the Agency's stated

intention to publish a list of drugs proposed for FRF exclusion and solicit stakeholder feedback on such proposal(s). As the Agency evaluates drugs for exclusion from the FRF, we respectfully recommend that consideration be given to the frequency with which lower utilization drugs are nonetheless commonly subject to comprehensive prior authorization or utilization management criteria; because the FRF is integral to plans' submission of such criteria for CMS-required approval, we are concerned that the elimination of such drugs from the file will make it difficult for plans to obtain necessary approvals unless an alternative to current processes is also established. We look forward to review of the Agency's proposed exclusionary list and to continued dialogue on the foregoing, related issue.

The Letter also requests comment on the possibility of moving the summer formulary update window later than the July 27-31 period used for 2018. As the Agency notes, sponsors must finalize their formulary submissions with enough time to meet printing deadlines. Importantly, plans do not only need time to have materials printed – following formulary finalization, plans must also verify initial data integrity, review file and print layout, approve proofs, transfer actual printed samples, and conduct final quality control before printing at volume. Given the scope of plan activity and review required to ensure accuracy and quality of printed formularies, we do not believe that it is advisable to move the summer formulary update window later than the end of July. The 2018 summer update window resulted in an operationally compressed timeline, and we believe that further compression would only raise the likelihood of errors and the costs of expedited printing and shipping. We respectfully ask that the Agency set the summer formulary update window for 2019 no later than the end of July.

Improving Drug Utilization Review Controls in Medicare Part D: Concurrent DUR

Cumulative Morphine Milligram Equivalent Daily Dose (MME) Safety Edits for High, Chronic Prescription Opioid Users (p.207)

The Letter reiterates current guidance that generally requires Medicare Advantage plans to approve prescribed opioids in excess of applicable MME hard edit thresholds based solely on the attestation of a prescriber that an exception is medically necessary, without any further information. Plans who wish to impose further or additional requirements are required to submit such proposed standards to CMS through the annual formulary submission process; this process is administratively burdensome as applied to such a scenario, and fails to account for the flexibility that may be needed to adjust these types of limits in response to changing prescribing patterns or populations throughout the year. In addition, plans are generally prohibited from applying more stringent prior authorization criteria to all drugs in a given class (e.g., opioids).

While we recognize that prescribing physicians may appropriately prescribe comparatively high dosages or quantities of medications for a certain limited subset of

patients, we also believe the opioid epidemic is a uniquely challenging public health crisis that merits the use of uniquely strong, targeted interventions. Given the clinical significance of prescribing in excess of established hard edit thresholds, we are concerned that merely requiring a summary statement of medical necessity represents an ineffective control; one that inadvertently discourages otherwise appropriate collaboration between plans and prescribers. In addition to collecting a statement that affirms medical necessity, we recommend allowing plans, for all drugs in the opioid class, to solicit additional clinical information from providers; such information could include but not be limited to the member's specific diagnosis, whether trials of clinically appropriate non-opioid drugs and/or non-pharmacological treatments were tried, and the existence of a treatment plan to taper the cumulative opioid dose.

Access to Medication-Assisted Treatment (p.216)

The Letter reaffirms prior Agency guidance prohibiting plans' use of authorization criteria for Medication Assisted Treatment (MAT) drugs (e.g., buprenorphine/naloxone) that duplicates criteria established pursuant to the Drug Addiction Treatment Act (DATA) of 2000. As a result, while MAT providers are obliged to comply with DATA requirements, plans are effectively not permitted to enforce such compliance through the prior authorization process. Unfortunately, statutory enforcement of these requirements is necessarily limited, more likely to occur only on a retrospective basis, and for practical reasons may be limited to only egregious incidents (which of course represent the rarest of exceptions). Plan prior authorization processes offer an active and accessible means through which CMS could more effectively promote compliance with DATA requirements and, as with all prior authorization policies, plans' authorization criteria would be subject to annual review and approval by CMS. We respectfully urge the Agency to reconsider its position on this issue and permit plans to adopt and apply MAT prior authorization criteria that reflects the related standards and requirements under the Drug Addiction Treatment Act of 2000.

We again thank the Agency for affording issuers and other stakeholders the opportunity to provide input on proposed changes to the Medicare Advantage and Part D program(s) for 2019. We appreciate your consideration of these comments and look forward to continued collaboration with CMS in the future.

Respectfully Submitted,

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