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March 5, 2018

Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare

Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director, Part C & D Actuarial Group, Office of the Actuary

Submitted Electronically via <https://www.regulations.gov>

RE: Advance Notice and 2019 Call Letter

Dear Mr. Kouzoukas and Ms. Wuggazer Lazio:

In response to the release of the Advance Notice and draft 2019 Call Letter published on February 1, 2018, HealthPartners submits comments for consideration.

HealthPartners is a not-for-profit plan sponsor and holds four contracts with the Centers for Medicare & Medicaid Services (CMS). They are H2422 (MA D-SNP), H2462 (1876 Cost), S1822 (Employer Group PDP), H4882 (MA PPO). Our Cost and D-SNP contracts are 4.5 star plans and our PDP contract is a 5-star plan.

HealthPartners is an integrated care delivery system and is driving change that helps our members live healthier lives at lower costs. Through our unique wellness programs, innovative provider payment approaches which incent and reward quality, and convenient member tools and services, we are able to provide better value for our members. By partnering with providers, members, purchasers, and the community, we are leveraging our capabilities to develop initiatives which improve health, member experience and affordability.

HealthPartners is a member of the Alliance of Community Health Plans (ACHP), the Special Needs Plans (SNP) Alliance and America's Health Insurance Plans (AHIP). We share their concerns with the Advance Notice and draft Call Letter and support their comments submitted under separate cover.

Advance Notice

Attachment II. Changes in the Part C Payment Methodology for CY 2019

1. Section A. MA Benchmark, Quality Bonus Payments and Rebate (page 9)

As more counties hit the pre-ACA caps for benchmarks thus negating Quality Bonus Payments, high-performing plans like HealthPartners have fewer incentives to continue to invest to maintain high quality care and member service.

Recommendation: We urge CMS to consider ways to remove Quality Bonus Payments from the pre-ACA caps, or find another way to reward high-performing plans.

2. Section H. CMS-HCC Risk Adjustment Model for CY 2019 (p. 30) – HealthPartners supports the expanded diagnosis codes for mental health and substance abuse, and the addition of a diagnosis code for chronic kidney disease, stage 3. We believe the additional diagnoses will improve the payment accuracy of the model for these conditions. However, we are concerned that initial analyses suggest that the proposed Patient Condition Count (PCC) will lower scores for Full Benefit Duals with a high number of HCCs. We understand that this outcome is driven by CMS’s choice in bucketing the number of HCCs in the model.

Recommendation: While we support the concept of the PCC model, we urge CMS to implement it in such a way that is not biased against this high-risk population.

[Attachment VI. Draft CY 2019 Call Letter](#)

[Section I – Parts C and D](#)

- 1. Annual Calendar (page 100)** - The annual calendar includes key dates and timelines for operational activities that pertain to Medicare Advantage and Part D plans. However, the timeframes for sub-regulatory guidance are not soon enough given the breadth and scope of proposed changes in the MA and Part D proposed rule for 2019.

Recommendation: We recommend that CMS move up relevant timelines for issuance of sub-regulatory guidance upon release of the final rule to ensure that plans have access to necessary guidance and sufficient lead time to implement changes for 2019. For example, the annual calendar indicates that the 2019 Medicare Marketing Guidelines (MMG) would be released sometime between mid to late June 2018. Many provisions in the Medicare Advantage and Part D proposed rule for 2019 impact the marketing rules such as the proposed flexibilities for benefit designs, revised definition of marketing, and rules related to the new open enrollment period. Releasing sub-regulatory guidance as expeditiously as possible would help ensure successful implementation of these new requirements.

- 2. Enhancements to the 2019 Star Ratings and Future Measurement Concepts and Reminders (page 106)** - The current methodology for establishing cut points allows for large year-over-year changes (up or down) when there is relatively little change in the distribution of scores. This is contrary to CMS goals of stability over time and putting improvement in ratings under the control of the plan. Also the measure cut points need to reflect meaningful differences in plan performance.

Recommendation: CMS implement the following changes:

- Set caps to the range of cut point changes to limit volatility.
- Set predetermined cut points so plans and providers have targets to strive for.
- Retire measures when there are 1 percentage point differences in the same direction between cut points year over year (e.g., 3 years).

- 3. New Measures and Changes to Existing Measures for 2019 Star Ratings (page 107)** - Under the MACRA, Section 1851 was amended to allow Medicare Cost plans to transition to the MA program. If certain conditions are met, the Medicare cost plan can notify its members that they are being passively enrolled in a successor MA plan with enrollment effective January 1, 2019. As part of this deeming provision, Section 1851(e)(2)(F) gives these individuals who were passively enrolled from the Cost plan to the successor MA plan until the end of February 2019 to change their election. The Cost plans that will be transitioning to the MA program anticipate that a large number of enrollees will be passively enrolled through this process. It is reasonable to expect that a portion of these members will realize that they would prefer another option and switch plans during this two month period. We believe that it is not the intent of Measure C29 that

these disenrolling individuals be counted as part of this measure because these individuals would not have had experience with the new MA plan that would have resulted in the decision to disenroll.

Recommendation: CMS modify or clarify measure C29 – Members Choosing to Leave the Plan to exclude individuals whose enrollment was deemed from a Cost plan to a successor MA plan from the measure.

4. **Removal of Measures from Star Ratings (page 112)** - HealthPartners supports retirement of the current BAPP measure and looks forward to working with CMS on a new measure.
5. **Temporary Removal of Measures from Star Ratings (page 113)** - We agree with the temporary removal of the Reducing Risk of Falls measure until the impact on results from the measure's wording change can be evaluated.
6. **Data Integrity (page 113)** - HealthPartners does not support CMS' policy to automatically downgrade rating scores to 1 star for non-appeals measures.
Recommendation: CMS work with plans and other relevant stakeholders to consider alternative approaches to the current policy for non-appeals measures such as scaled reductions for all measures and ensuring that penalties are not applied inappropriately. For example, where the data submission error is identified early on, is not egregious or systemic, and is curable during the plan preview period.
7. **Proposed Scaled Reduction for Appeals IRE Data Completeness Issues (page 114)** – We support CMS's proposal to use scaled reductions for the appeals measures for 2019 Star Ratings.
Recommendation: CMS not use TMP data until CMS and plans are assured that the results from the TMP are accurate and reliable for use in the agency's data integrity reviews. We also recommend that CMS ensure that during the TMP process plans have an opportunity to work with the IRE to address and resolve data discrepancies that warrant reconsideration.
8. **2019 Star Ratings Program and the Categorical Adjustment Index (page 122)** - The CAI was intended as an interim adjustment to account for disparities in a plan's performance associated with social economic status tied to contract level enrollment of LIS/dual individuals and disabled individuals. As CMS has noted the CAI has had minimal impact on plan star ratings and we have experienced firsthand a negative adjustment that lowered our overall star rating from 5 stars to 4.5 stars. CMS should not penalize high-performing plans for lower population of LIS/dual individuals and disabled individuals.
Recommendation: CMS recalibrate the CAI so that the lowest adjustment is zero and the maximum adjustment is increased accordingly. Alternatively, CMS hold plans harmless from reductions in star ratings due to the CAI.
9. **2019 Display Measures - New Changes (page 140)** – CMS states that plan's performance "may be artificially improved" by the exclusion of dismissed and withdrawn cases but no clear rationale for the concern. Also, the proposal does not address those cases that are not under the plan's control.
Recommendation: CMS not move forward with the proposed appeals measure. If CMS chooses to do so, increase the minimum denominator of 10 cases to a higher, statistically valid number. Also, exclude cases when there is a CMS or Maximus error that results in a dismissal.

10. Potential Changes to Existing Measures (page 145) - HealthPartners supports inclusion of the encounters (both Medicare-covered and supplemental benefits) in various Part C quality measures including behavioral health services.

Recommendation: CMS treat remote access technologies visits the same as in-person visits. Medical practice is changing to incorporate more remote access technologies and we encourage CMS to incorporate these changes.

11. Potential New Measures for 2020 and Beyond (page 148) - HealthPartners agrees with the exploration of observational-based care coordination measures rather than the current method of enrollee self-reported measures of care coordination.

12. Measurement and Methodological Enhancements (page 156) – We support the use of improvement measures but not the weighting of 5x. This higher weighting diminishes the value and importance of clinical measures and misleads beneficiaries about which are the highest quality health plans. In addition, the application of both Part C and Part D improvement measures penalizes plans that have significant gains in one Part of Medicare. Allowing for the inclusion of either the Part C or Part D improvement measure acknowledges and rewards a plan's improvement and is a reasonable extension and application of CMS' hold harmless provision.

Recommendation: CMS implement the following changes:

- Reduce the weight of improvement measures to 3x.
- Allow for the inclusion of either the Part C or the Part D quality improvement measure if including only one of the measures would improve the plan's overall score.

13. Validation Audits (page 159) - HealthPartners supports the validation audit improvement recommendations by CMS. The validation audit comes on the heels of a very time consuming program audit and the validation audit continues to require a significant level of intensive resources and has a financial impact to an organization. Overall, we believe these are positive changes that support successful completion of a validation audit.

Recommendation: We have a few recommendations for consideration of final guidance.

- First, CMS increase the number of non-CPE conditions. The proposal notes a three percent decrease in plans that would hire an independent auditor, which is not very significant. We recommend CMS increase the number of conditions and would like to know the impact of moving the threshold upwards of 8 conditions.
- CMS continue to allow extensions to address unforeseen circumstances beyond the proposed 180 days. Please provide confirmation in the final Call Letter that extensions will be allowed. Furthermore we ask CMS to provide a general timeline of the activities to be completed during the revised timeframe. For example, include the average time to plan for remediation issues, average timeframe to contract with an auditor, and/or, average time for CMS review for conflict of interest with the independent auditing firm.
- Lastly, please confirm how long the exception for CPE would be good for.

14. Plan Finder Civil Money Penalty (CMP) Icon or Other Type of Notice (page 164) - We have concerns with CMS' proposal to include a Civil Monetary Penalty (CMP) feature on Medicare Plan Finder (MPF). It will lead to beneficiary confusion and not promote an apples-to-apples comparison of plans. We note that beneficiaries already have access to CMP information since CMS posts CMPs on its website. Below are concerns and issues we have with including a CMP feature on the MPF.

Recommendation: CMS not adopt it in the final Call Letter for the reasons noted below.

- Complexity and Range of CMPs. Since the majority of CMPs issued stem from CMS program audits, this seems to negatively impact plans that are subject to a program audit. Additionally, CMS can levy CMPs for a wide range of compliance issues and the penalty amount of CMPs varies significantly due to CMS's complex calculation formula that involves a number of adjustment factors. Given the complexity and range of CMPs, we believe that beneficiaries would have a very difficult time assessing and using CMPs to compare plan options. It is also unclear if CMS would include the icon for all CMPs assessed or if there would be a CMP threshold.
- Increase Beneficiary Confusion. MPF already includes a lot of detailed information about plans' quality, cost, and coverage that beneficiaries must navigate and consider. Adding CMPs to MPF would complicate (not enhance) beneficiary decision-making. The icon would undoubtedly lead to confusion, create unnecessary alarm, and highlight something that may not be of concern.
- Additional Concerns. We are also concerned that CMS does not address the length of time that the CMP icon or notice would be on display or how CMS would handle cases where a CMP has been levied but is under appeal. It is also unclear if CMS would be posting the results of their enforcement actions throughout the year instead of just one time per year, please clarify.

15. Enforcement Actions for Provider Directories (page 165) - We continue to believe that CMS should consider the validity and accuracy of directories be contingent upon receipt of updated and accurate information by providers. Maintaining accurate provider directories is a shared responsibility that requires a commitment from both health plans and providers to ensure beneficiaries have the information they need and that the directory information is updated in a timely and accurate fashion. We continue to encourage CMS to work collaboratively with the industry on technology solutions to reduce provider burdens to notify plans of changes.

Recommendation: CMS' compliance and enforcement activities need to take into account reasonable efforts made by the plan to obtain information from network providers and not penalize the plan when their providers fail to provide updated or accurate information in a timely manner. We also ask that CMS provide a definition of "egregious" instances of non-compliance to ensure consistent application and understanding across the industry. Lastly, we respectfully request CMS share best practices of what they do on the FFS side to keep their provider information current as the industry is open to suggestions on how to improve the validity and accuracy of provider directories.

16. Audit of the Sponsoring Organization's Compliance Program Effectiveness (page 165) - HealthPartners supports this proposal and believe it eliminates duplication of work and efforts as discussed in the draft Call Letter.

Recommendation: In finalization of this proposal we recommend that CMS consider deeming for the following year those organizations that complete a Program Audit late in the year, Q3 for example, and complete their compliance program effectiveness audit early in the following year (Q1 and Q2). Organizations experiencing this timing would see much less benefit from the one-year time period not. Lastly, please clarify the trigger, or start date, of the one-year time frame. Perhaps it would be based on the date of the final audit report or audit closure date.

17. Special Needs Plan (SNP) Legislative Sunset Provision (page 168) - HealthPartners is very pleased that Congress has passed legislation providing permanency for all SNP types since release of the draft Call Letter. We look forward to the opportunity to work with CMS and other partners to streamline and improve operational deadlines and provisions.

18. Health Related Supplemental Benefits (page 182) - HealthPartners is in support of the proposed additional flexibility.

Recommendation: CMS provide clarity around the expanded definition and include examples that fall under the expanded definition. Our specific requests for further clarification are as follows:

- First, we seek to better understand the CMS definition of "medically appropriate and ordered by a licensed provider as part of a care plan if not directly provided by one". Not all supplemental benefits, current or potential, would require this criteria i.e. nursing hotline, fitness benefit, iPad (for D-SNP). Please provide additional clarity how CMS expects plans to implement supplemental benefits under the expanded definition that do not require 'ordering by licensed provider as part of a care plan'.
- Second, clarify the intersection between the draft Call Letter health related supplemental benefit proposal and the Bipartisan Budget Act (BBA) of 2018. The BBA includes the expansion of benefits for chronically ill individuals for 2020, whereas the draft Call Letter doesn't appear to limit to a specific population and would be effective for 2019. Please confirm the expanded definition and benefit flexibility in the draft Call Letter would continue to be effective for 2019 and the BBA provisions would be an extension to this revision and apply 2020.
- Third, please provide clarification on how this provision will impact, overlap, or interface with the current flexibilities provided to certain high performing D-SNPs and FIDE-SNPs. HealthPartners expects CMS will consider how this flexibility will interact with existing Medicaid benefits. Highly integrated D-SNPs should be able to leverage the new benefit flexibility in their work with states to meet local needs to assure that benefits do not duplicate Medicaid benefits or those benefits targeted to members not eligible for them under Medicaid.

19. Medicare Advantage (MA) Uniformity Flexibility (page 184) - HealthPartners strongly supports CMS' new interpretation of Federal law so plans can reduce and eliminate barriers to health care for those members who meet certain objective clinical criteria.

Recommendation: Future CMS marketing guidance must ensure no member confusion regarding member eligibility and a level playing field with plans participating in the VBID program. This includes no marketing of reduced cost sharing or other benefit flexibility until post-enrollment and plan identification of eligible individuals. This will reduce member confusion as well as adverse selection concerns. In addition, we recommend CMS expand this flexibility to Part D benefits. We are not aware of any regulatory constraints that would prohibit this. Expansion would support a more comprehensive and holistic approach of medical and Part D coverage. Finally, CMS sub-guidance must be issued quickly after final rule making to allow plans time to adjust benefits and pricing for the bids.

20. Special Needs Plan (SNP)-Specific Networks Research and Development (page 185) - HealthPartners supports the concept of SNP specific networks. A properly constructed SNP network would help plans more effectively tailor the network for high-need, high-risk populations. A SNP specific network should be more flexible than current MA network requirements and be appropriate for the SNP population and access needs. SNP networks should not be more restrictive or difficult to achieve than current MA

requirements and should be tailored to meeting the needs of this population. Additionally, Minnesota Minnesota Senior Health Option (MSHO) plans have continued to have success and an overall improved experience through the updates to the network adequacy process. We encourage CMS to reference these updates as guidance and support for updating this process.

Recommendation: CMS build on the successes and learnings from MMPs, which have tested SNP specific network standards utilizing a dual eligible member file for network testing of dual eligible programs, which we support. We believe this proposal would benefit from a collaborative effort between CMS and plans offering SNPs which allows review and comments by the plans. We have had good success with the MSHO/MMP exceptions process, and encourage CMS to embrace the inclusion of technological innovations that provide access beyond traditional brick and mortar providers - mobile clinics, e-visits/telehealth, etc. that address access issues.

21. Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs (page 187) -

HealthPartners, as a part of the demonstration in Minnesota, has benefited from administrative alignment and integration. We appreciate and support CMS in expanding these opportunities beyond the demonstration status, building on the experiences of the current MMP and Minnesota demonstration plans.

22. Formulary Submissions (page 193) - HealthPartners supports the changes to allow an enhancement-only window, January formulary submission window, and elimination of the Non-Extended Day Supply (NDS) file. We see each change as very positive and streamlining the formulary submission process.

Recommendation: In finalizing the formulary submission timeframes, the summer update window should occur at the end of July or early August. This still provides sufficient time to meet print deadlines to keep document preparation activities on track for timely completion for the AEP.

23. Improving Drug Utilization Review Controls Under Part D (page 202) - HealthPartners supports the numerous proposals including limiting opioid prescription fills to 7 days or less.

Recommendation: CMS clarify what is considered a opioid naive patient. For example, does this definition include any opioid filled within the past 4 months, other timeframe, or other criteria to consider?

24. Using the Best Available Information when making B vs D Coverage Determinations for

Immunosuppressants and Inhalation DME Supply Drugs (page 218) - HealthPartners is concerned that a prior use of an immunosuppressant drug does not automatically correlate to a transplant.

Recommendation: CMS provide more clarification on the expectation to confirm if the immunosuppressant drug is used for transplant purposes and valid sources to obtain this information.

Thank you for the consideration of our comments. If you have any questions regarding our comments, please feel free to contact me at 952-967-5117 or Amy.L.Schultz@HealthPartners.com.

Sincerely,

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