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Good Afternoon:

Thank you for the opportunity to submit comments on the *Advance Notice of Methodological Changes for Calendar Year 2019 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter (CMS-2017-0163)*. UCare provides the following comments for consideration.

CMS-HCC Risk Adjustment Model for CY 2019 (page 30)

CMS has not released the modeling software or enrollee level detail regarding the new risk adjustment models, nor has CMS been able to publish a consistently accurate MAO-004 report that is critically important for reconciling encounter data submissions. Therefore, UCare strongly recommends delaying the new model implementation one year, which would still allow for the full phase-in by the 2022 federal legislation mandate in the 21st Century Cures Act.

ESRD Risk Adjustment Model for CY 2019 (page 30)

UCare supports the updated data in ESRD risk model change.

Frailty Adjustment for PACE Organizations and FIDE-SNPs (page 34)

UCare recommends that CMS review Programs of All-Inclusive Care for the Elderly (PACE) plans and Fully Integrated Dual Eligible (FIDE) Special Needs Plans (SNPs) frailty factors on an equitable basis. PACE plans exist for enrollees who are frail but still living in the community (the nursing home certifiable population). UCare's FIDE-SNP caters to this demographic, but it also covers an equally large proportion of community-well enrollees in addition to institutionalized enrollees. UCare urges CMS to consider calculating frailty for FIDE-SNPs on the same basis as the PACE plans. That is, only evaluate frailty for the nursing home certifiable enrollees and apply the frailty adjustment on that same basis. In the current environment, nursing home certifiable enrollees in the FIDE-SNP must have frailty scores that are much greater than PACE plans so that the average frailty level across both community-well and nursing home certifiable enrollees are at least as big as the nursing home certifiable enrollees from PACE plans.

UCare also disagrees with how the HOS and HOS-M surveys are administered. There are no interpreters allowed for these surveys and only a very small number of languages are available for beneficiaries to use. More than 25% of our FIDE-SNP population does not speak English. Our two largest minority populations are Hmong and Somali (nearly 20% of the 25%). Neither of these ethnicities can take the current survey and produce valid results. Furthermore, the

culture surrounding these two ethnicities is family-oriented and elderly are most often cared for in the community setting. These are enrollees who fall into the nursing home certifiable population. However, language barriers prohibit them from being counted in the HOS surveys. This erroneously skews UCare's surveyed enrollees toward community-well enrollees, creating an even bigger frailty differential to overcome.

Finally, it is not equitable that FIDE-SNPs are being compared to the average PACE plan frailty level. Our FIDE-SNP has been very close to meeting the frailty threshold during many of the historical plan years. Because we are compared to the average PACE frailty, it seems likely – despite receiving an underreported frailty level – that UCare's FIDE-SNP is actually considered more frail than some of the PACE plans. Yet, PACE plans with less frail populations still receive the frailty adjustment while UCare and other FIDE-SNPs in our situation do not.

Medicare Advantage Coding Pattern Adjustment (page 35)

UCare supports following the statutory minimum coding adjustment.

Normalization for the CMS-HCC Model (page 38)

Please see the previous comments under *CMS-HCC Risk Adjustment Model for CY 2019* regarding delaying the new model implementation.

Encounter Data as a Diagnosis Source for 2019 – Part C and D (page 42 and 45)

Please see the previous comments under *CMS-HCC Risk Adjustment Model for CY 2019* regarding delaying the new model implementation. Additionally, although UCare does not have comments about the blend percentages at this time, we do not support the new model until more information is released.

Annual Calendar (page 100)

UCare requests that CMS allow Medicare Advantage Organizations (MAOs) the flexibility to send Evidence of Coverage/Member Handbooks to integrated dual eligible SNP (D-SNP) enrollees by a date that aligns with the state Medicaid program deadlines (i.e., December 31, 2018).

Enhancements to the 2019 Star Ratings and Future Measurement Concepts (page 106)

New Measures for 2019 Star Ratings (page 107)

Statin Use in Persons with Diabetes (Part D). In the absence of an adherence component, UCare does not support increasing the weight of this measure to three.

Changes to Measures for 2019 (page 108)

Members Choosing to Leave the Plan (Part C & D). UCare supports expanding the exclusions for this measure because it is unfair to penalize plans for disenrollments in situations where a product is closed or no longer offered in a county and there are no other products offered in that county that an enrollee is eligible to enroll in.

Removal of Measures from Star Ratings (page 112)

Beneficiary Access and Performance Problems (BAPP) (Part C & D). UCare supports CMS' proposal to change the data timeframe for data used in the civil monetary penalty portion of the BAPP measure calculation to the time period from July of the measurement year to June of the following year. Changing the data timeframe will allow for use of more recent data and therefore will represent a more accurate reflection of current plan performance/compliance. We also support CMS' proposal to solely include Compliance Activity Module data in the modified display version and their decision to revise the measure in a way that decouples audits and enforcement actions from the Star Ratings. Should CMS decide, in the future, to return the modified BAPP display measure to the ratings, UCare recommends that it be assigned a weight of 1, as a process measure, and not the previous weight of 1.5.

Data Integrity (page 113)

SNP Care Management and Medication Therapy Management Part C and D Reporting Requirements Measures. UCare does not support this proposed methodology. A more appropriate methodology is a scaled decrease in the Star Ratings based on the data validation Likert scale finding. For example, a finding of "No" on the Likert scale is a worse finding than a three; however, this proposal treats both findings the same and reduces the measure to one Star.

Proposed Scaled Reductions for Appeals IRE Data Completeness Issues. UCare supports the proposal to move to a scaled reduction methodology for data integrity issues tied to the appeals measures. UCare encourages CMS to consider using this methodology for other ratings measures. Additionally, UCare suggests that CMS allow MAOs a time frame in which to cure erroneous data.

2019 Categorical Adjustment Index (CAI) Values. UCare believes that the CAI is a step in the right direction, but fails to sufficiently account for the impact of low income subsidy and dual eligible (LIS/DE) enrollees on the Star Ratings measures. UCare encourages CMS to aggressively pursue additional steps to address the fundamental unfairness of the existing Star Ratings methodology for MAOs serving a high percentage of LIS/DE enrollees.

We support the CMS premise that measure stewards should incorporate risk adjustment into all measures and that LIS/DE should be evaluated as a risk adjustment factor for each measure where the data shows it to be material. Until the measures are modified to include risk adjustment, we encourage other forms of relief for predominantly LIS/DE products, such as separate cut points for D-SNP products that compare performance against other D-SNPs.

Disaster Implications (page 130)

UCare supports the CMS strategies to address Star Ratings issues for contracts impacted by extreme and uncontrollable circumstances.

2019 CMS Display Measures (page 140)

Plan Makes Timely Decisions about Appeals (Part C). UCare does not support including IRE dismissals in timely decisions, because dismissals are for cases that plans did not review as appeals at all. They are administrative denials made because the appeal was not filed timely or the requestor was not a valid party.

Hospitalizations for Potentially Preventable Complications (Part C). CMS should take care to ensure that the predicted probability of discharge and predicted count of discharge logic is recalibrated to successfully predict observation stays. The timeline for inclusion of the measure in the Star Ratings should be driven by CMS confidence in the accuracy and reliability of that logic. Additionally, observation stays are used to determine the need for hospital admission and are considered outpatient services. Including outpatient stays in a measure of hospitalizations may be inconsistent with the actual measure.

Potential Changes to Existing Measures (page 145)

Controlling High Blood Pressure (Part C). UCare expects there will be a period of adjustment for physicians as they adapt their diagnosis coding to the new hypertension treatment guidelines. This adjustment period may result in some inconsistency and unreliability in the data. If a change is made, the measure should be moved to display until the results stabilize.

Plan All-Cause Readmissions (Part C). The proposed timeline suggests that, for 2020, MAOs may be required to report both the old version of the measure and the new version of the measure. Certified HEDIS software vendors may not support this, which would create a massive burden for MAOs.

Initiation and Engagement in Alcohol or Drug Dependence (AOD) Treatment (Part C). UCare requests clarification on why CMS is proposing to include self-harm and asphyxiation diagnostic codes in this measure.

Cross-Cutting Exclusions for Advanced Illness (Part C). UCare suggests that the Breast Cancer and Colorectal Cancer Screening measures end at age 69, because most physicians do not pursue these screenings for patients in their 70s. UCare also recommends removal of the Osteoporosis measure, because it results in unnecessary testing.

For each of these measures, it is unlikely screening or treatment will be ordered by treating physicians, given the advanced disease burden for these enrollees.

<u>Potential New Measures for 2020 and Beyond</u> (page 148)

Transitions of Care (Part C). UCare suggests that this be considered a hospital measure, not a MAO measure, because MAOs have minimal impact on these types of measures. This measure does not translate well for open access MAOs where enrollees may not have clearly defined medical homes or primary care physicians. Also, the transfer/readmission logic may not account for situations where enrollees have outpatient periods in between linked inpatient periods during which appropriate services are rendered, but do not count.

Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C). UCare does not support this measure. There is minimal clinical utility to this measure given the lag between the time of emergency department visit and the time the MAO learns of the visit and is able to connect with the enrollee.

Care Coordination Measures (Part C). UCare does not support this measure. Network MAOs will be disadvantaged by this measure because the measures have minimal impact on transitions of care to hospitalization. Hospitals often lag in reporting admissions, and enrollees are cared for by hospitalists, not by primary care physicians.

Assessment of Care for People with Multiple High-Risk Chronic Conditions (Part C). UCare does not support this measure. The measure as described will likely require 100% chart review, which is burdensome and statistically unreliable for Star Ratings. NCQA-mandated sample sizes of 411 are based on achieving a rate of plus or minus five percent. For Star Ratings, a swing of five to ten percentage points from year to year may move a plan up or down multiple Star levels for no reason other than random variation. UCare encourages CMS to focus on measures that have large denominators and that can be reported by means of administrative data.

Depression Screening and Follow-Up for Adolescents and Adults (Part C). UCare does not support this measure. While UCare agrees that this is an excellent best practice, MAOs want to have multiple options for the clinical screening tool providers are required to use. Further, Electronic Clinical Data System measures, at this stage of national health information technologies, are purely aspirational and not appropriate for Star Ratings. Most MAOs do not have shared medical records across their entire network available at the point of care, and they have no ability to mandate their use by providers. If used, this measure would only be reported by a small number of integrated plans, which would likely not represent a large enough group to create meaningful cut points for the Star levels. CMS should focus on measures that are reportable by MAOs.

Adult Immunization Measure (Part C). UCare enthusiastically supports moving away from survey-reported methodologies for services that are objectively measureable, due to issues with enrollee recall, enrollee ability to understand questions and reliance on a less knowledgeable third party to assist with the survey. However, ECDS is not a viable methodology for most MAOs. In the absence of a reliable way to gather this data, UCare recommends eliminating this measure.

Anxiety (Part C). UCare supports quality measures for assessing anxiety disorders as long as the measure includes clear parameters and is driven by diagnosis or prescriptions and not by self-reported information.

Measurement and Methodological Enhancements (page 156)

Development of Non-Claims Based Measures. UCare supports non-claims based measures that use pharmacy data or other administrative sources available to MAOs. However, UCare does not support non-claims based measures that use surveys, chart reviews or ECDS.

Validation Audits (page 159)

Conflict of Interest Limitations on Independent Auditing Firms (page 161)

UCare questions why CMS does not use the conflict of interest standards currently established for data validation auditors. Also, UCare requests that CMS define "management consulting."

Required Use of CMS Validation Audit Work Plan Template (page 162)

UCare supports the use of a work plan template and appreciates that CMS will request public comment on the template in a *Federal Register* proposed information collection.

Timeframe to Complete Validation Audits (page 163)

UCare supports this change, but notes that CMS must continue to allow ad hoc extensions to the timeframe.

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

UCare does not support adding a CMP icon or other type of notice on the Medicare Plan Finder, because a CMP icon will result in beneficiary confusion. In addition, simply noting a MAO received a CMP does not provide the public with an accurate and current picture of the MAO. For example, displaying a CMP icon in late 2018 for a CMP a MAO received in 2017 for an issue the MAO corrected in 2017 is outdated and misleading – and does not serve to educate the public.

Further, the public is unlikely to distinguish between CMPs, which vary. In 2016, the average audit-related CMP was over $350,000, but the range was from $3,325 to $2,498,850 (see the *2016 Part C and Part D Program Audit and Enforcement Report*). And, because it strains credibility to believe the public will know why there is a range in CMPs (see the March 1, 2017 *Civil Money Penalty Enforcement Actions for 2016 Program Audits HPMS Memorandum*, which noted that "The majority of CMPs are assessed on the number of enrollees impacted by a violation. In most instances, the amount of the CMP will be higher for larger sponsors with more enrollees or where a violation impacted a larger number of enrollees"), we do not understand how it is equitable that a MAO that received a CMP of $3,325 (because few enrollees were

impacted) would receive the same CMP icon as a plan that received a CMP of $2,498,850 (because a large number of enrollees were impacted).

Lastly, MAOs may appeal CMPs, which could result in the CMP being overturned. If an appeal is underway, it would be misleading to display the CMP icon. Potential enrollees who saw the CMP icon may continue shopping elsewhere and never learn that the CMP was eventually overturned. Although we strongly disagree with the CMP icon, if CMS finalizes this proposal, an icon should not be displayed until all appeals are exhausted.

Special Needs Plan (SNP) Legislative Sunset Provision (page 168)

We are very pleased that D-SNPs now have permanent status and look forward to continuing to work with CMS on further advancing integration of services to dually eligible enrollees.

Coverage of Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (page 182)

UCare requests clarification regarding which Plan Benefit Package categories are appropriate for the SET for PAD services.

Medicare Advantage (MA) Uniformity Flexibility (page 184)

UCare supports CMS' interpretation for uniformity.

Medicare Advantage (MA) Segmented Service Area Options (page 185)

UCare supports CMS' interpretation of the regulations governing plan segments.

Special Needs Plan (SNP) Specific Networks Research and Development (page 185)

UCare supports CMS' ongoing collaborative approach to maintaining and developing network adequacy criteria. For example, we appreciate CMS' release of the provider information used in its health service delivery calculations, as this improved our ability to evaluate provider data accuracy.

UCare also supports CMS' ongoing monitoring of population distributions and updating of county access standards. For example, Saint Louis County, MN is an exceptionally large, mainly rural county with a concentrated metropolitan area at the southern edge, and application of metro time/distance criteria resulted in network adequacy challenges year after year. CMS recently changed the county type for Saint Louis County from Metro to Micro, which we believe more accurately reflects the population distribution and will improve the network adequacy review process.

Rewards and Incentives for Completion of a Health Risk Assessment (HRA) (page 186)

UCare agrees that a completed HRA is vital to proper care management, improved health and promotes the efficient use of health care resources. HRA completion rates are low for the under-65 dual population. The option to provide an HRA incentive gives the health plan another tool to understand enrollee health needs post-enrollment, to better coordinate care and to connect the enrollee to needed resources. Therefore, we strongly support allowing MAOs to include the completion of an HRA as a permitted health-related activity in a Rewards and Incentives program.

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

UCare supports CMS' continued efforts to align benefits and improve coordination for dual eligible enrollees. We thank CMS for collaborating with Minnesota to develop integrated model materials.

Expanding the Part D OTC Program (page 196)

UCare requests clarification regarding whether Part D sponsors will be required to submit to CMS the over-the-counter drug products referenced in the utilization management criteria in a supplemental OTC drug file.

Improving Drug Utilization Review Controls in Medicare Part D (page 202)

Retrospective DUR (page 204)

Opioid Potentiator Drugs. UCare supports adding flags to the Overutilization Monitoring System for opioid potentiator drugs and encourages CMS to add flags for drug classes that have the potential to interact with opioids. These drug classes would include sedative hypnotics, muscle relaxants, and stimulants.

Concurrent DUR (page 207)

Cumulative Morphine Milligram Equivalent Daily Dose (MME) Safety Edits for High, Chronic Prescription Opioid Users. UCare has concerns about the seven-day limit for enrollees who are currently on therapy that is greater than 90 MME per day. This is not an adequate period of time for enrollees to coordinate with their prescribers and pharmacies to resolve their issues. UCare recommends that CMS allow these enrollees to transition their care in the same manner as enrollees experiencing a regular negative formulary change year over year. This will allow the standard transition communication timeframes to occur and allows enrollees a sufficient amount of time to transition.

Days Supply Limits for Opioid Naïve Patients. UCare supports the implementation of a seven-day fill limit for opioid naïve patients, which will help prevent the inadvertent use of opioids by enrollee or associates of enrollees. This initiative aligns with many industry practices in the

Medicaid and commercial lines of business. In fact, UCare and health plans are implementing a similar initiative in Medicaid in 2018.

Access to Medication-Assisted Treatment (page 216)

UCare agrees that access to medication-assisted treatment is important and that there should be no access barriers for these medications.

Sincerely,

Ghita Worcester
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UCare