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Good Afternoon,

Thank you for the opportunity to submit comments on the proposed rule, *Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)*. UCare provides the following comments for consideration.

Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability

Flexibility in the Medicare Advantage (MA) Uniformity Requirements. UCare supports flexibility that allows plans to design MA plans around the targeted needs of different Medicare populations and promotes informed consumer choice when comparing plans. UCare is especially supportive of flexibility that would allow plans to provide certain supplemental benefits only to fully integrated dual eligible Special Needs Plan (FIDE-SNP) enrollees who do not meet nursing home level of care requirements that would otherwise make them eligible for home and community-based services under an Elderly Waiver.

Segment Benefits Flexibility. UCare supports the proposal to vary supplemental benefits by segment. We agree that 42 CFR 422.262(c)(2) does not preclude differing MA benefit designs across plan segments, so long as the benefit is identical for all enrollees within a given segment.

Maximum Out-of-Pocket (MOOP) Limit for Medicare Parts A and B Services. UCare supports the proposal to allow more flexibility in setting MOOP limits. MOOP is a great way to protect enrollees from unforeseen high costs. Allowing flexibility for determining the appropriate MOOP, with strong consideration for stability, seems appropriate. We agree that increasing the number of services with cost sharing flexibility would help steer plans toward the voluntary MOOP. This could also be accomplished by reducing cost sharing amounts for plans with mandatory MOOPs.

Meaningful Differences in MA Bid Submissions and Bid Review. UCare supports the proposal to eliminate the meaningful difference requirement. Removing the meaningful difference test will allow flexibility in designing products that are more suited to our enrollees.

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Coordination of Enrollment and Disenrollment through MA Organizations and Effective Dates of Coverage and Change of Coverage. UCare supports the updated seamless conversion process. In general, the consumer protections seem appropriate and the conditions appear reasonable. It is important that CMS requires beneficiaries who do not speak English as a primary language receive outreach in their language, possibly both by mail and telephone.

Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries. UCare supports this authorization because it is focused on ensuring continuity of integrated coverage for duals in the event of procurement or plan non-renewals. We encourage CMS to require two notices for impacted beneficiaries and possible telephonic outreach for beneficiaries from whom the notices were returned, as well as for beneficiaries who do not speak English as a primary language.

Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries. UCare does not support limiting continuous SEP for dual eligible beneficiaries out of concern that it keeps these beneficiaries from achieving their best coverage. While duals may not exercise their ability to elect a plan change via the continuous SEP in large numbers, this may reflect beneficiaries' lack of understanding of the SEP and how to use it rather than the value that continuous flexibility can potentially offer them in improving their coverage. If the SEP for duals is limited in any way, we support the second alternative - to modify the SEP so that it can only be used to elect enrollment into an integrated Medicare Advantage-Prescription Drug plan (e.g., D-SNP). This ensures that the flexibility is applied to improving the integration and coordination of coverage. Once the election into integrated care is made, that may represent a reasonable point at which to limit the SEP to once a year. Any outreach to communicate changes to the SEP must go beyond mailed English-only materials. There must be community-based outreach in multiple languages to ensure that duals of all communities are aware of the availability of this choice.

MA and Part D Prescription Drug Plan Quality Rating System

Stakeholder Feedback on Specific Topics. UCare supports reviewing limitations to existing Star measures and improving these measures to reflect accurate outcomes. The Health Outcomes Survey (HOS) measures are of particular interest for improvement. The survey has problems in design, methodology and reporting that disproportionately affect SNP populations. This survey is problematic due to its lengthy look-back longitudinal design, lack of translated material for most languages and methods for sampling and administration. We believe it is overdue for re-examination, and a study focusing on diverse, dually-eligible beneficiaries is warranted.

UCare suggests that modifications to the cut point calculation (removing outliers prior to applying the clustering logic, or raising the minimum denominator threshold from 30 to 100 to reduce the number of outliers based on small numbers) might modify the cut points in a way that provides meaningful differentiation for measures where performance is generally high.

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UCare does not support the use of measures based on physician experience surveys, because integrated plans with structural connections to providers would have an advantage over non-integrated plans. Integrated providers would likely have easier access to health plan enrollee information (such as a health risk assessment) compared to non-integrated providers.

Contract Consolidations. UCare supports the creation of calculation rules of Star Ratings for consolidated contracts. This would eliminate the gaming that can occur when multiple contracts of distinct geographic areas and different Star Ratings are combined into a single contract, and the highest rated contract determines the Star Rating of the new single contract, regardless of its enrollment size. This gaming artificially inflates the Star Ratings and reduces plan comparability based on quality, resulting in inaccurate signals to beneficiaries on which to base plan selections.

Adding, Updating and Removing Measures. In regards to new measures, UCare supports advancing the announcement to plans in order to allow for quality readiness. UCare supports keeping these new measures on the display page for a two year minimum. CMS should adopt a consistent threshold to determine which measures are transitioned to the display page. For example, if more than 50% of contracts score in the 5 Star category, the measure should be proposed for display only.

Data Integrity. UCare supports CMS' proposed methodology for scaled reductions for appeal measures, and would support the application of a similar methodology for Healthcare Effectiveness Data and Information Set (HEDIS) measures.

CMS' proposal to reduce a HEDIS measure to 1 Star when audited data are submitted to NCQA with an audit designation of "biased rate" would result in unequal impact across contracts. For example, reduction of a measure from 5 Stars to 1 Star would have a greater negative impact to the contract's overall Star Rating than another contract being reduced from 2 Stars to 1 Star for the same measure. UCare suggests that plans be allowed a time frame, potentially during the plan preview period, to cure data.

Measure-Level Star Ratings. The method of grouping all MA plans together masks significant underlying differences in the dual eligible populations. We suggest stratifying plans (based on dual enrollment status), which would allow for accurate comparisons within relevant cohorts of plans that share key population characteristics.

Measure Weights. UCare does not support increasing the weight of patient experience/complaints and access measures. Instead, UCare encourages CMS to attribute greater weight to data-driven measures and less on enrollee survey measures. The enrollee survey measures consist of subjective responses open to interpretation and are dependent on accurate recall from enrollees. This is of particular concern for populations with low health

literacy and educational levels or high cognitive impairment. CMS could also consider adding cultural, ethnic and language differences to their current case mix methodology for HOS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Categorical Adjustment Index (CAI). UCare appreciates CMS' continued recognition of the low income subsidy/disability effect and the commitment to improve methodology to address the unique challenges of these populations. We encourage CMS to continue to explore solutions that more robustly address the full impact of how changing demographics and social determinants affect health outcomes. For example, CMS could add additional measures to create a more robust effect.

Plan Preview Star Ratings. UCare supports the continuation of the plan preview periods for review of Star Ratings each year.

Improving the CMS Customer Experience

Lengthening Adjudication Timeframes. UCare supports changing the timeframes from seven to 14 days.

Elimination of Medicare Advantage Plan Notice for Cases Sent to the IRE. UCare appreciates CMS' effort to streamline the appeal process, but we do not believe eliminating this notice benefits the enrollee. We feel it is important to tell the enrollee how we have resolved their appeal as soon as we have made a decision. Waiting for the IRE to provide this information causes a delay in communicating the decision to the enrollee and could result in increased calls to the plan.

Reduction of Past Performance Review Period. UCare supports the reduction of the past performance review period from 14 months to 12 months. The current 14 month period is unfair because non-compliance occurring in January and February is double counted (i.e., in two review cycles).

Sincerely,

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