March 5, 2018

Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Principal Deputy Administrator Kouzoukas:

On behalf of Highmark Inc., I am writing to offer comments on the **Advance Notice of Methodological Changes for Calendar Year 2019 for MA Capitation Rates, Part C and Part D Payment Policies and CY 2019 Call Letter (CMS-2017-0163)**

Headquartered in Pittsburgh, Pennsylvania, Highmark is the fourth largest Blue Cross Blue Shield affiliated organization and provides health insurance in Pennsylvania, West Virginia and Delaware. One of America's leading health insurance organizations with over 5 million covered lives, Highmark's mission is to deliver high quality, accessible, understandable and affordable experiences, outcomes and solutions to customers. Highmark and its Blue-branded affiliates proudly cover the insurance needs of millions of individuals, families and seniors, offering a variety of products and services to meet their healthcare needs.

As part of our mission, Highmark strives to deliver affordable, high quality coverage to Medicare beneficiaries in the markets we serve and has a deep and longstanding commitment to the Medicare Advantage program. We have been offering Medicare Advantage plans to beneficiaries for over 20 years and currently offer MA plans in Pennsylvania and West Virginia. We have nearly 270,000 Medicare Advantage members, making us the largest Medicare Advantage insurer in Pennsylvania. We are also proud of the quality we deliver to our Medicare Advantage members, which is evidenced by the fact that 99% of our MA members are in 4.5 Star rated plans.

Our specific comments are below:

Advanced Notice

Attachment II

MA Benchmark—Section A5

Highmark believes the cap on benchmark payments diminishes incentives to improve care and quality as the benchmark cap can remove the entire quality bonus payment – thus removing the desired payment differential between poorly performing plans and high performing plans.[1] We encourage the

[1] According to MedPAC, 19 percent of MA enrollment (and 45 percent of counties) is affected by caps on the high quality benchmarks. Those beneficiaries are enrolled in high-quality MA plans in bonus-capped counties, and

Administration to review the legal analysis provided by the Blue Cross Blue Shield Association that provided a pathway for the agency to administratively lift these caps such that bonus payments are outside the cap application.

Calculation of FFS Costs—Section B

Highmark would also like to take this opportunity to advocate for basing the FFS cost estimates on data from members who have both Parts A and B coverage. Currently, CMS uses the experience of all members in a county including those that only have Part A coverage. Medicare Advantage plans must cover both Part A and Part B benefits and the FFS cost estimates should be calculated consistently with the coverage being offered. The current methodology that blends the experience of members with and without Part B coverage underestimates the true cost of providing care for both parts A and B.[2] Indeed, MedPAC has recommended that the FFS calculation should be corrected to ensure that the population that is used to calculate the FFS spending is representative of the expected spending for MA beneficiaries.

MA Employer Group Waiver Plans—Section G

CMS is proposing to fully transition in 2019 to using only individual market plan bids to calculate the bid-to-benchmark (B2B) ratios to set EGWP payments or alternatively, maintaining the payment methodology that was applied in calculating the 2017 and 2018 MA EGWP payment rates (i.e., using a blend of all individual market plan bids and all EGWP bids). To place the issue into context, we note that the demographics and risk profile of Medicare eligible individuals insured through group Medicare Advantage plans differs substantially from the general Medicare population, so we believe that it is less accurate to rely on the individual market MA bids as the sole basis for determining EGWP costs and reimbursement. Highmark's MA EGWP book of business, for example, includes labor groups that are particularly prone to expensive conditions resulting, in part, from decades in industries such as mining and steel work. They are more expensive than average beneficiaries.

The 2017 reduction in MA EGWP funding has pushed many employers to consider eliminating group-sponsored retiree benefits. We believe that avoiding further funding reductions will help re-stabilize the employer group market. Further, this will assist employer sponsors or retirement funds with longer-term bargaining arrangements time to adjust to the new rating methodology. Highmark actuaries estimate that fully implementing the funding change will increase premiums and/or reduce benefits by approximately $10 per member per month for Highmark's nearly 100,000 MA employer group members.

Of the two options, Highmark supports using individual PPO experience to be used in the bid-to-benchmark ratio for individual as this is more reflective of the preponderance of PPO plans in the EGWP market. However, in order to best reflect the experience of the employer group population and stabilize the employer group market over time, we support reverting back to the pre-2017 methodology of using EGWP experience as the determinant for costs and funding.

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the plans they are in are losing some or all of their quality bonuses. MedPAC, *Report to the Congress: Medicare Payment Policy,* "Chapter 12: The Medicare Advantage program: Status report," March 2016.

[2] According to MedPAC, about 20 percent of each of the Hawaiian, Portland, OR, and Pittsburgh, PA, FFS populations do not buy Part B. *Id.*

Encounter Data as a Diagnosis Source for 2019—Section N

CMS has proposed increasing the blend of risk scores from Risk Adjustment Processing System (RAPS) and Encounter Data System (EDS) to 25% EDS data and 75% RAPS in 2019. Highmark asks that CMS reconsider increasing the weight of EDS given the continued concerns that encounter data is still relatively new and faces unresolved issues regarding both accuracy and operations. For one, CMS' use of EDS for quality measurement purposes is still in its infancy. Further, the findings of the recent GAO performance audit of CMS operations from June 2016 to January 2017 indicates a need for further research and evaluation.[3] In addition, a recent Office of the Inspector General (OIG) report found that there are still significant issues that inhibit the completeness and accuracy of encounter data.[4] As a result of this uncertainty, Highmark would support keeping the current weighting of the data. Further, we recommend that any new calculation would remain in place, fixed at the time of bids, until such a time that issues around EDS accuracy and operations have been resolved adequately such that a full year of reliable RAPS and EDS data is available for release and testing by the plans by mid-February in advance of the following year's bids.

Call Letter

Section I

2019 Star Ratings

- **Categorical Adjustment Index (CAI)**

  While Highmark supports the concept of the CAI, Highmark is concerned over the implementation of the CAI. First, these CAI values are adjusted retroactively, which effectively raises the bar for plans with Low Income Subsidy/Dual Eligible (LIS/DE) /Disabled membership from achieving their Stars goals. The Overall Rating CAI value given to contracts in Final Adjustment Category A has doubled from a 0.021 Star reduction in 2018 to a 0.041 Star reduction in 2019. The new Category A reduction has the same impact as a 3-weighted measure decreasing by one star. This is problematic, because contracts rely on providers, vendors and other stakeholders to drive Stars outcomes. When thresholds are effectively raised retroactively, plans are unable to align measure-specific targets with their contracted partners to achieve outcomes. Highmark respectfully requests CMS provide CAI adjustment values prior to the beginning of a measurement period.

  Additionally, Highmark strongly recommends adjusting the methodology to include a hold harmless provision for contracts that would have their overall Star rating decreased solely as a result of CAI application. This would be consistent with the hold harmless provision that is used for the Quality Improvement (QI) measures.

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[3] U.S. Government Accountability Office, *Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments*, GAO-17-223, January 2017, https://www.gao.gov/assets/690/682145.pdf.
[4] U.S. Department of Health and Human Services, *Medicare Advantage Encounter Data Show Promise for Promise Oversight, but Improvements are Needed,* OEI-03-15-00060, January 2018, https://oig.hhs.gov/oei/reports/oei-03-15-00060.pdf.

The spirit of QI is not to penalize consistently high performing contracts that perform flatly from one year to the next, but rather to give additional credit to contracts that demonstrate noticeable improvement year over year. In order to prevent the unintentional penalization of high performing contracts, the hold-harmless provision was established to prevent dropping 4+ star contracts by a half-star solely due to not demonstrating significant year-over-year improvement to qualify for the QI lift.

Recognizing that the underlying rationale of the CAI is to place contracts with high proportions of LIS/DE/Disabled members on a level playing field with the other plans to which they are compared, a similar hold-harmless provision would prevent penalizing 4+ star contracts solely for not having higher proportions LIS/DE/Disabled members.

As noted in the 2019 Draft Call Letter, the application of the CAI resulted in one contract losing a half-star in Star Year 2018. Without the protection afforded by a hold-harmless provision, it is likely that even more contracts will see a reduction in the Overall Star Rating in 2019 solely due to the CAI, since the Category A reduction has doubled..

- **Risk Adjustment of the Adherence Measures**

Highmark appreciates and supports the effort to explore methodologies for quality measurement that represent true differences in quality rather than reflections of changes in the composition of beneficiaries in contracts. However, should CMS pursue the draft risk adjustment recommendations for Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS Antagonists), and Medication Adherence for Cholesterol (Statins), Highmark urges CMS to provide sufficient information to allow plans to monitor the impact of this change.

The availability of rate information that reflects exactly how plans will be evaluated is crucial to their ability to take appropriate action and better calibrate their activities over the course of the performance period. This in turn gives plans the ability to produce clear and actionable performance targets for their provider and pharmacy networks. Such targets are critical to drive outcomes related to medication adherence and patient safety. Therefore, it is essential to receive adherence rate information with the risk adjustments applied on a regular basis, not only at the close of the performance period. CMS could facilitate the exchange of this information in two potential ways: provide risk adjustment statistics in the monthly patient safety reports, or provide the methodology and data used to enable plans to calculate the impact themselves.

- **Beneficiary Access & Performance Problems (BAPP)**

In the CY 2019 MA and Part D Proposed Rule which aims to codify the processes by which CMS will add, update, and remove Star Rating measures, all new measures would be on the display page for a minimum of two years prior to becoming a Star Ratings measure. Providing this period for evaluation and review fosters stability and transparency in the Star Ratings System and permits new measures to be fully defined, tested and validated. Highmark fully supports this approach. As such, Highmark respectfully requests the new BAPP measure abide by this same process, due to the fundamental change in technical specifications. Exclusive reliance on CAM data should be

thoroughly examined by CMS prior to its implementation as the sole metric by which plan beneficiary access and performance problems are assessed. The two year display page time frame is necessary to accommodate this vital review process. Therefore, Highmark requests the new BAPP measure remain on the display page for 2019 and 2020 Star Ratings.

- **Members Choosing to Leave the Plan**

  Highmark appreciates the efforts to explore new exclusions and respectfully requests CMS create an additional exclusion for the Members Choosing to Leave the Plan measures. Highmark recommends adjusting the measures (Part C and Part D) to provide an exclusion for members who disenroll from a plan within one H-contract and enroll in another plan within a separate contract offered by the same parent organization.

  When a member switches from one contract to another under the same parent organization, there is an adverse impact to the Star rating for the first contract. This assumes that a poor experience was the key driver behind the member's decision to leave his/her contract. However, this is not always the case. Health plans continue to drive innovation and improvement across their product offerings as the needs and priorities of members change over time. Therefore, health plans are continuously working to ensure they offer products that meet these evolving needs. Just as a beneficiary may choose to switch from one PBP to another within the same contract, he or she may also elect to move to another contract entirely.

  This is especially true in dynamic markets that feature continuous and transformational changes across health systems. For instance, Highmark sees cases in which our PPO members may be better served in our HMO, and cases where HMO members may be better served in our PPO. CMS' current policy penalizes MAOs when its beneficiaries switch contracts, even if the rationale behind the switch is fully in the best interest of the beneficiary. As health plans innovate to meet these market demands, their Star ratings should not suffer when beneficiaries ultimately remain with the same parent organization. Therefore, Highmark strongly recommends the development of an exclusion within the Members Choosing to Leave the Plan measure (Part C and Part D) that addresses this issue.

- **Measure Weighting**

  Highmark supports triple-weighting measures that relate to outcomes because they have an important effect on members and therefore should play a significant part in overall Star ratings. However, it is important to be rigorous about the definition of an outcome measure, because every time a new measure is upgraded to 3-weight, it effectively dilutes the amount that the other 3-weight measures contribute to the overall Star rating. Highmark has concerns regarding the current and proposed designation of certain measures as "outcomes-based." These are:

  - **Statin Use for Persons with Diabetes (SUPD)**

    Highmark opposes the proposal to increase the weight of this measure to 3. Compliance for this measure only requires a single prescription fill, which in and of itself does not represent

an ultimate outcome. In order for medications to truly contribute to an outcome, regular adherence is required over a course of treatment, as is evidenced by the 3-weighted classifications of the medication adherence measures.

- **Improving/Maintaining Physical Health & Improving/Maintaining Mental Health**

  Highmark believes using a subjective qualitative survey of a very limited sample of member populations to evaluate these critical outcomes falls well short of an accurate representation or gauge of health outcomes. First, these measures are assessed via the Health Outcomes Survey (HOS), which is subjective in nature, given the fact that is based on members' perception of their health, rather than objective clinical data. Secondly, the requirements of the survey allow for beneficiaries to complete the survey by proxy, and this proxy can differ between the baseline and follow-up survey two years later. Such requirements add to the subjectivity of responses. Highmark contests that clinical evidence would provide the most accurate representation of the evolution of member physical and mental health, and to that end encourages further research in measurement based on more reliable clinical data. Therefore, Highmark strongly recommends that CMS decrease these to a 1.5 weight (consistent with most other survey measures) for the time being until an alternative clinical data-based method of evaluation can be established.

- **Plan All-Cause Readmissions**

  Highmark supports the proposal to revise this measure to include observation stays in both the denominator and numerator. Such a modification would more accurately reflect the experiences of beneficiaries, and it would permit a more equitable comparison among contracts with varying practices about admission reimbursement.

- **Medication Adherence Proportion of Days Covered Adjustment for Inpatient Stays and Hospice Enrollment**

  Highmark supports the expansion of this adjustment. However, we are requesting clarification on whether or not this will also include observational stays, which we recommend. Members would be similarly situated in terms of presumed access to medication and adherence regardless of the designation of their stay as "observational."

Section II

Meaningful Difference (Substantially Duplicative Plan Offerings), Part C Optional Supplemental Benefits, and Health Related Supplemental Benefit, and MA Uniformity Flexibility

Highmark applauds the steps that CMS has taken to enable plans to be more responsive to beneficiaries' unique needs and greater opportunity to provide value including the introduction of more flexibility within uniform benefit requirements, elimination of meaningful difference requirements, and more

flexibility to offer supplemental benefits. We are looking forward to more clarification about the timing for implementation and further guidance about these opportunities.

Transparency & Timeliness with Prior Authorization Processes

We appreciate that CMS acknowledges that MAOs are permitted to utilize utilization management techniques such as prior authorization in delivering benefits within their provider networks. While we strive to make the PA process as transparent and straightforward as possible for the member, we wish to raise a few important practical considerations from a plan perspective:

With respect to administering PA through a plan's network providers, we have observed that provider staff have difficulty managing all the PA requirements, not due to a lack of information provided by the plan, but due to the complexity in navigating between different MAOs, plan types, and services that require PA. We appreciate the burden facing contracted providers; however, current CMS guidance hinders their ability to fully review appeals for appropriateness of services being requested and ensure services are covered and reimbursable under the Medicare program, essentially necessitating the application of a PA requirement.

Second, while CMS focuses on concerns associated with the PA process itself, we also wish to raise your awareness of the unique challenges faced by plans with out-of-network benefits (i.e., PPO, HMO-POS). For these plan types, PA is generally permitted but not required.[5] In reality, MAOs with these plans receive very limited PA requests as there are no requirements or guidelines for non-contracted providers (as between the MAO and provider) to provide any information to the MAO. The burden is placed on the member to discern that PA might be beneficial for him or her and ensure a PA or claims review is completed. Further, the burden of obtaining plan pre-authorization documents—particularly in light of Plan-Directed Care updates to Chapter 4: Benefits and Beneficiary Protections of the Medicare Managed Care Manual—is significant, as providers cannot use standard CMS documents and must use individual MAO notification materials.

Accordingly, the lack of guidance for non-contracted providers, combined with the disparity between MA and FFS rules, complicates the ability of plans and providers to effectively coordinate care for a beneficiary. More importantly, these challenges often burden beneficiaries with administrative and financial liabilities and do not hold non-contracted providers accountable, as they can bill the beneficiary if the MAO does not pay. Additionally, even if the beneficiary is referred only for a consultation or specific service, the MAO is liable for any service the non-contracted provider renders.

We note that if the plan determines that the service provided would not have been reimbursed under FFS—even in the case of care rendered outside of NCD/LCD guidelines—the only option is to deny the request and issue an Integrated Denial Notice (IDN), which places beneficiary liability on the service.

[5] In sharp contrast, under the FFS program, providers are held accountable for notifying members with an Advance Beneficiary Notice of Non-coverage (ABN) in situations where Medicare payment is expected to be denied. The ABN is not an MAO document. Under FFS, if the provider failed to either bill with the modifier showing the ABN was issued or produce the plan-specific document, the provider is held accountable. Under MA rules, the plan is responsible. Furthermore, when beneficiaries are referred outside of the plan network, the MAO is liable for all services.

While this decision can be appealed, the non-contracted provider is not required to do so and can bill the member directly due to the denial being issued to the member.

If the plan wants to shield the beneficiary from financial and administrative burdens, the only option is to pay the Medicare rate of reimbursement for the actual codes submitted by the Non-Contracted Provider, even if FFS would not allow the member to have the burden of the appeals process. Even if upheld by the IRE, the member is still liable—a result that Highmark disagrees with. However, the current Non-Contracted Provider Dispute process does not allow for these types of decisions to be disputed and only reviews whether the rate of payment is correct; we note that this does not cover site of service decisions like non-contracted providers billing for inpatient DRG admissions when an observation level of care was appropriate. While there are guidelines that protect the beneficiary from liability, none hold the non-contracted provider accountable for following the FFS rules of rendering only Medicare covered services or providing advanced notification. Thus, the plan pays for services that would not otherwise be covered by the Medicare program.

Highmark recommends modifications to current out-of-network regulations in order to remove the Medicare beneficiary liability and hold the plan and providers accountable to Medicare guidelines.

Section III

Improving Drug Utilization Review (DUR) Controls: Part D Opioid Overutilization Policy and Retrospective DUR

We support the inclusion of potentiator drugs of gabapentin and Lyrica. However, we are concerned about the administrative burden of the OMS review process. This expansion in scope will increase the volume of identified beneficiaries.

Although we agree that measures should be taken to limit beneficiary exposure to opioids, we believe that a hard edit at 90 Morphine Milligram Equivalent (MME) will be both disruptive to members and administratively burdensome to plans. Provider attestation is the basis on which we make a coverage determination decision. Therefore, without strict criteria that are easy to follow, a strict MME edit will unlikely deter providers or beneficiaries from overuse, misuse, and abuse of opioid medications.

- We agree with the goal of aligning plan policies and procedures to CDC guidelines. However, we are concerned about adverse member impact that could result from limiting opioids to a 7 days' supply and the short lead time to complete and test such complex coding.
- Although soft edits are a useful tool, we wonder if there will be "pop up fatigue" with these types of soft point-of-service (POS) edits. These drugs have multiple edits—both hard and soft. The utility of another soft POS edit may not be as impactful as intended.

Concurrent DUR

- **Cumulative MME Safety Edits for High, Chronic Prescription Opioid Users**
    - With respect to the section referencing the 90 MME hard edit where the packaging is only available in a supply greater than 7 days, we would not expect any supply to be

provided, as this would require sophisticated coding and testing to verify coding is working as intended. Because these drugs already have multiple edits, this policy increases the risk of false positives and the payment or rejection of inappropriate claims.

- In response to the expectation that the Part D sponsor only rely on prescriber attestation that the higher MME is medically necessary to approve dosing that is higher than the hard edit when a coverage determination is requested, we believe that provider attestation is extremely vague and is not clinically impactful without stricter criteria. Providers are playing a role in the opioid epidemic and the allowance of an attestation does not hold the provider significantly accountable.

- **Days' Supply Limits for Opioid Naïve Patients**
  - With respect to limiting to one 7 days' supply, we feel this would unduly impact members adversely and is inconsistent with clinical practice. As written, the policy does not allow for more than one acute injury. Further clarification is requested for the provision of a finite timeline for the initial 7 day limitation, e.g., one 7 day fill in a 6 month period.

Access to Medication-Assisted Treatment

We agree with limiting PA/ST review to once per plan year. Currently, we carry approvals across plan years. We ask for clarification regarding whether it is CMS' expectation that plans carry approvals across plan years, or continue authorizations indefinitely once an approval is on file. If continued approval is the intent, we request that CMS provide guidance on whether plans must or may reevaluate the need for medication, as MAT is intended to be discontinued after the member successfully weans off opioids.

Using the Best Available Information when Making B vs. D Coverage Determinations for Immunosuppressants and Inhalation Durable Medical Equipment (DME) Supply Drugs

We are in favor of these clarifications.

On behalf of Highmark, I thank you for considering our comments. My team and I are happy to discuss our concerns with you. Please contact my office at 412-544-4393.

Sincerely,

Jean Rush
Executive Vice President, Government Markets
Highmark Blue Cross Blue Shield

cc: Deb Rice-Johnson, President, Highmark Health Plan
Daniel Onorato, Executive Vice President, Highmark Health