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MEDICA®

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically: http://www.regulations.gov

Re: 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)

Dear Administrator Verma:

Thank you for the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' ("CMS") proposed rule entitled "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," ("proposed rule") published in the Federal Register on November 28, 2017. Medica[1] (also referred to as "we," "our," or "us,") is an independent and nonprofit health care organization with approximately 1.2 million members, and is Minnesota's second largest nonprofit provider of health insurance and related services. Medica's mission is to be the trusted health plan of choice for customers, members, partners, and our employees. Medica offers Medicare Cost Plans in Minnesota, Wisconsin, and North Dakota, and South Dakota serving about 160,000 members.

Medica appreciates many of the policies and intentions announced in the proposed rule, and supports the following changes as proposed:

- the changes to the meaningful difference in Medicare Advantage bid submissions and bid review,
- coordination of enrollment and disenrollment through Medicate Advantage organizations ("MAOs") and effective dates of coverage and change of coverage,
- Medicare Advantage plan minimum enrollment waiver,
- revisions to timing and method of disclosure requirements,
- discontinuing the Quality Improvement Project for MAOs, and

[1] "Medica" refers to the family of businesses that include Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured and Medica Health Management, LLC, as well as sister organizations Medica Foundation and the Medica Research Institute.

- the proposed implementation of the Comprehensive Addiction and Recovery Act of 2016 ("CARA") provisions.

In general, Medica supports policies that foster innovation, increase choice, reduce administrative costs and burdens, and protect members. The above mentioned proposals are important steps to achieving those policies.

Our comments and recommendations to the proposed rule are divided into four topic categories. First, we urge CMS to provide greater regulatory flexibility during the Cost Plan transition as doing so will minimize disruption and confusion for beneficiaries. Second, we offer suggestions for clarifying which provisions of the proposed rule apply to Medicare Cost Plans. Third, we offer feedback on the proposed changes to the Medicare Advantage uniformity requirements. Lastly, we offer recommendations on elements of the proposed rule that relate to operational improvements.

Accordingly, on behalf of Medica, I respectfully submit the following comments to CMS:

I. Cost Plan Transition

While Cost Plans tend to serve sicker, older beneficiaries, they maintain high quality ratings with lower out-of-pocket costs. The Medicare Payment Advisory Commission ("MedPAC") and the Government Accountability Office ("GAO") have both reported that Cost Plans have higher quality scores than MA plans on average.[2,3] In addition to higher quality, Cost Plans are important options for beneficiaries because they differ from MA plans in terms of out-of-network coverage, enrollment periods, and prescription drug coverage.

Over half of the Medicare beneficiaries currently enrolled in Cost Plans will receive plan cancellation letters in 2018 and will have fewer choices as a result. Beneficiaries will be forced to enroll in a new plan with a different benefit structure or face a return to fee for service Medicare. Seniors will have to navigate new networks, formularies, and cost-sharing arrangements. Therefore, we ask CMS to support a smoother transition for seniors enrolled in Medicare Cost Plans by implementing regulatory policies that ensure cost plan members have the option to keep their plans, which will cause the least amount of disruption and greatest choice for Minnesota seniors.

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[2] MedPAC March 2011 Report. Available here: http://www.medpac.gov/docs/default-source/reports/Mar11_EntireReport.pdf?sfvrsn=0.
[3] GAO 2009 Report. http://www.gao.gov/assets/300/299934.pdf.

Two Plan Test

Section X of the Medicare Access and CHIP Reauthorization Act of 2015[4] ("MACRA") established new requirements for Medicare Cost Plans and allows such plans to transition to Medicare Advantage ("MA") plans. Among the requirements is the "two plan test," which states that a Cost Plan "may not be extended or renewed for a particular service area if such area was within the service area of 2 or more MA plans of the same type (regional or local) during the entire previous year (provided that all such plans are not offered by the same MA organization)."[5] As a result, Cost Plans may not be renewed where two or more MA plans are operating, even if the Cost Plan has a higher star rating than one or both MA plans or if MA penetration is low in a particular service area.

II. Clarifying Application to Medicare Cost Plans

We strongly recommend CMS take star rating into account by interpreting the two plan test as requiring CMS not extend or renew a cost reimbursement contract for a service area only when there are two or more MA plans with an equal to or higher star rating than that of the Cost Plan. The proposed interpretation is consistent with the goals of the Medicare program and is within CMS' authority. Further, we would like to note that CMS has exercised this authority when implementing similar statutory provisions relating to the Medicare managed care program in the past. Star rating is one of the most important measurements of a plan's quality and therefore, in order to ensure beneficiaries have access to the highest quality care star ratings should be taken into account.

One of our primary thematic suggestions in response to the proposed rule is that CMS should clarify which of the provisions in the proposed rule apply to Medicare Cost Plans. Although the preamble of the proposed rule sometimes indicated when a proposal would apply to the Medicare Cost Plans, we recommend CMS explicitly state in the codified regulations and in the preamble of the final rule which provisions apply to Medicare Cost Plans.

III. Flexibility in Medicare Advantage Uniformity Requirements

CMS proposed a variety of policy changes intended to foster innovation and allow for additional plan choices in the market. The proposed rule would allow MAOs to develop additional products that are tailored to specific market or enrollee needs. One such proposal would modify the

[4] Pub. L. 114-10, Section X. Available here: https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf.
[5] Soc. Sec. Act § 1876(h)(5)(C)(ii).

Medicare Advantage uniformity requirements. While in principle, this proposal may increase consumer choice, and provide greater flexibility and variation in the market, Medica has concerns about this proposal.

CMS proposes to permit MAOs to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that all similarly situated enrollees are treated the same. We believe this change is unnecessary if CMS adopts the proposed changes to meaningful difference. We also believe this may be administratively burdensome to implement, such that there may not be equal adoption across all MAOs. Therefore, Medica does not support this proposal.

IV. Proposed Operational Improvements

CMS recently began a process by which it seeks to increase efficiencies, reduce unnecessary burden, and improve the Medicare Advantage beneficiary experience and CMS proposals several changes to effectuate these policies.

A. Medicare Advantage and Part D Prescription Drug Plan Quality Rating

CMS proposes to codify core aspects of the Part C and Part D Star Ratings methodology, and will include the principles for adding, changing, and retiring measures, as well as the methodology for calculating and weighting measures. One of CMS' themes is to establish a more person-centered care approach in the Quality Ratings Program. Specifically, CMS proposes changes to quality ratings after contract consolidations, an updated process for adding, updating, and removing measures, improvement measures, measure weights, and application of the improvement measure scores, and we provide comments those proposals.

1. Quality Ratings after Contract Consolidations

CMS proposes to modify the Star Ratings calculation for surviving contracts that have consolidated by aligning and displaying Star Ratings based on the enrollment-weighted mean of the measure scores of the surviving and consumed contracts to reflect the performance of all contracts. Medica supports this proposal, as it brings better transparency and accuracy to beneficiaries on the actual quality of the contract surviving the consolidation.

2. Adding, Updating, and Removing Measures

CMS proposes specific rules for updating and removing measures that would be implemented through sub-regulatory action, so that rulemaking will not be necessary for certain updates or removals. Under this proposal, CMS would announce application of the regulation standards in the Call Letter attachment to the Advance Notice and Rate Announcement. We support the longer timeline from proposing a measure to rating and quality bonus payment based on the measure, as it allows more time for collaboration to address current performance and implement improvement plans. CMS is not, however, requiring an independent measure steward, and we recommend that a measure steward should be required for all clinical measures as a way to improve validity and reliability. We support CMS' proposal that all new measures will be displayed for a minimum of two years.

We offer two recommendations on specific measures. First, to support CMS' person-centered care approach in the Quality Ratings Program, we recommend CMS consider adding a new measure on palliative care, and that the HEDIS Advance Directive measure should be included in the Quality Ratings Program. Determining how a member manages chronic illness, and how they document their end of life decision making approach impacts every beneficiary, and allows for a more person-centered approach to medical care and intervention for the Medicare population. Second, we recommend CMS remove the rheumatoid arthritis measure. CMS states that one of its guiding principles is to select measures based on the prevalence of conditions or importance of outcomes. The rheumatoid arthritis measure does not apply to many members, and members' experiences with the common treatments can be negative due to uncomfortable side effects. Conversely, lung and brain diseases are becoming much more prevalent among the population. We recommend the quality measures CMS chooses should reflect this prevalence, and would support the removal of the rheumatoid arthritis measure.

3. Improvement Measures

CMS proposes a process for calculating the improvement measure score(s) and a special rule for any identified improvement measure for a contract that received a measure-level Star Rating of 5 in each of the two years examined, but whose associated measure score indicate a statistically significant decline in the time period. Medica has concerns about this proposal, as the same hold harmless does not apply to sponsors of plans who have the same set of circumstances, but received a measure-level Start Rating of 4; in that instance, the plan would experience a significant decline in its improvement score calculation. We suggest that CMS either apply the hold harmless to the 4-star level plans, or not adopt the hold harmless for 5-star level plans, so as to ensure equitable treatment of plans in similar circumstances.

4. Measure Weights

CMS proposes to continue the current weighting of measures in the Part C and Part D Star Ratings program by assigning the highest weight (5) to improvement measures, followed by outcome and intermediate outcome measures (3), then by patient experience/complaints and access measures (1.5), and finally process measures (1). We do not support the proposed weighting of improvement measures, and believe the weight should be reduced to 3, as it is for all other outcomes measures.

B. Preclusion List

CMS proposes eliminating provider enrollment requirements that were expected to become effective in 2019. CMS proposes, instead, to compile a "Preclusion List" of individuals and entities that fall into one of two categories. MAO and Part D plan sponsors would be required to deny claims from or written by prescribers and providers on the Preclusion List.

Medica generally supports CMS' proposal, but we have questions about the operationalization of this proposal. For example, we recommend CMS clarify whether MAOs and Par D plan sponsors have to provide a 90-day supply before denying claims due to the prescriber or provider being on CMS' Preclusion List.

C. RFI on Reducing Provider Burden

While CMS did not offer any regulatory changes in the proposed rule, it seeks comments from stakeholders to more fully understand provider burden and for ideas to accomplish reductions in provider burdens. CMS specifically solicited comments on the "frequency of requests for providers to submit medical records."

We appreciate CMS' willingness to learn more about how regulatory requirements impact industry. We expect CMS will receive numerous and detailed comments in response to this RFI. Medica, while not offering any specific suggestions, would like to caution CMS before implementing any changes to reduce burdens on providers, especially changes regarding medical records requests. Health plans request medical records from providers as part of the risk adjustment program, and their participation is critical to the accuracy of the risk adjustment program. We caution CMS on implementing any changes to medical records requests that may impact the risk adjustment program, but note that process alternatives controlled by providers could ease provider burdens, such as if they shared electronic medical records with health plans.

D. Reducing the Burden of Compliance Program Training Requirements

CMS proposes to delete the regulation requiring acceptance of CMS' training as meeting the compliance training requirements and the reference to first-tier, downstream and related entities in the compliance training requirements. Medica does not support CMS proposal. Although we understand CMS' policy rationale, we currently receive significant opposition from providers, and we rely on the existence of the federal regulation as compulsory evidence of their need to comply. Removing that regulation may reduce provider compliance, because health plans will not have a federal regulation to cite. We also note that CMS requires three different trainings, and the compliance program training requirements are not the sole source of provider complaints. If, however, CMS wishes to streamline the compliance program training requirements, we recommend CMS centralize collection so that providers only have to submit information to CMS, which would then make the information on compliance training requirements available to interested health plans.

E. Revisions to Communication/Marketing Materials and Activities

CMS proposes to focus its oversight of marketing communications on documents that are most likely to lead to an enrollment decision, and to define the category of materials outside that scope as "communications." CMS would still have oversight over communications, but it would be more streamlined.

We urge CMS to identify ways to improve communications with Cost Plan beneficiaries during the Medicare Cost Plan transition to minimize member disruption and confusion.

F. Changes to Agent/Broker Requirements

CMS proposes to eliminate the regulatory provisions that limit what MAOs and Part D sponsors can do when they have discovered that a previously licensed agent or broker has become unlicensed. We are concerned that CMS did not outline what is expected of MAOs and Part D sponsors, because the guidelines are necessary to avoid CMS compliance actions.

In addition to clarifying the requirements for MAOs and Part D sponsors when a previously licensed agent or broker becomes unlicensed, we also recommend that CMS consider adopting regulations that prohibit agents and brokers from being compensated at first year commission levels for members that are transitioned from Medicare Cost Plans to Medicare Advantage plans in 2019.

Thank you once again for the opportunity to provide these comments. Please do not hesitate to contact me if you have any questions or would like to discuss Medica's comments in more detail.

Sincerely,

Jay McLaren
Vice President, Public Policy and Government Relations
Medica