



January 16, 2018

Ms. Seema Verma, Administrator
Center for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Attention: CMS-4182-P

Dear Ms. Verma:

VIVA Health, Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) in response to its Request for Information on the proposed rule for the Medicare Program; 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. Comments are submitted in the following areas:

Coordination of Enrollment and Disenrollment Through MA Organizations and Effective Dates of Coverage and Change of Coverage §§ 422.66, 422.68

VIVA opposes any beneficiary opt-in or opt-out conversion policy from commercial to Medicare Advantage (MA). A single carrier has greater than 50% commercial penetration in many areas of the country and would be heavily favored by proposed policies to facilitate conversion to their same MA plans by any enrollment method. In states like Alabama where a single carrier dominates the commercial market (approximately 90% penetration), allowing an opt-in for MA puts the other MA plans in the state on a severely uneven playing field. Medicare Advantage has been one market where health plans have been treated equally and competition has thrived. Any conversion policy from commercial to Medicare (whether opt-in or opt-out) reduces the likelihood beneficiaries will make informed choices and creates unfair competition. Health plan designs offered to employers are typically very different from the MA plans offered by the same health plan (different premiums, cost sharing, benefits, formularies, authorization requirements and networks) and beneficiaries moving from commercial plans to Medicare are typically capable of making their own informed decisions after comparing available options.

MAPD Quality Rating System Comments

Contract Ratings

VIVA believes beneficiaries who compare MA plans are most interested in seeing plan ratings based on performance within the service area where they live. When a plan's membership is spread across multiple states, the result is a star rating that is not accurate for the beneficiaries' particular service area because they are a blend of rates for plan members in different geographies.

VIVA recommends calculation of a star rating for the population within each state a plan operates and for which the contract meets the minimum enrollment and measure reliability standards for a stand-alone contract rating (for example, a minimum of 500 members and a reliability score of 0.7). Measures that reflect centralized plan administrative functions, such as appeals and grievances, may be calculated once and reported with an enrollment weighted mean based on member location. Measures that reflect member-level performance and experience (such as CAHPS/HOS, health screenings and outcomes) would be calculated based on state level performance. VIVA acknowledges that this may result in extra administrative burden on the larger contracts operating in multiple states. However, this would support the CMS goal of making the ratings accurate for beneficiaries using Star Ratings, and equitable for all types of MA plans across the country (local, regional, and national.)

Adding, Updating and Removing Measures

VIVA is supportive of efforts to establish specific rules regarding adding, updating and removing measures. Awareness of new measures and changes to existing measures prior to the beginning of the performance period allows plans the ability to allocate resources appropriately and make necessary changes to operations as a part of an annual planning process. Plans and vendors need significant lead time to adjust supporting information systems, align quality performance programs, and plan any specialized educational materials and events.

VIVA also proposes CMS create defined implementation stages or categories during the star measure approval/change processes. Language around future measure additions, removals, changes can become confusing when issued in narrative form within the CMS Advance Notice/Call Letter documents and plans could benefit from clear measure implementation status designations or a grid.

VIVA particularly supports the proposal to place new measures on the display page for a minimum of two years (or longer if reliability and validity issues are identified). As part of the new measure inclusion evaluation, VIVA requests CMS to strongly consider the administrative burden placed on plans to collect data and report proposed measures and weigh whether the measures reflect MA plan performance as opposed to direct health care provider performance.

Multi-part measures that must be collected through medical record review strain plan resources, especially in the face of continually compressed HEDIS audit and data collection timelines by

NCQA. Additionally, measures that are reflective of experience with direct health care providers and measures reflective of direct health care provider operational processes consistently demonstrate a rating bias toward MA plans that directly employ health care providers.

VIVA acknowledges it is very important for health plans and health care providers to work together to improve members' care experience and share mutual accountability for optimal outcomes. However, these types of measures would more appropriately be included as display measures versus star rating measures since they do not reflect health plan performance and only indirectly measure health plan control or influence over their provider networks. This influence/control can vary widely by market area for valid reasons.

If direct health care provider type measures are retained within the star ratings calculation, we propose they be implemented concurrently into hospital, physician, and/or other applicable CMS provider pay-for-performance rating programs. This would afford health plans that do not directly employ health care providers more equitable treatment and improve plan leverage in influencing changes within their provider networks. This would also meet CMS's stated goal of aligning quality measures and decreasing disparity across the various CMS quality measurement programs.

Measure Level Star Ratings

VIVA appreciates CMS soliciting input on cutpoint methodology and the potential of establishing pre-determined cut points or ways to minimize fluctuations from year to year. VIVA proposes CMS establish maximum ranges within which cutpoints may increase or decrease each year for the various measures. Plans need more certainty in establishing performance expectations for quality improvement programs, provider incentive programs, and individual employee performance expectations within the current system. Plans and providers are investing significant financial resources and/or taking on financial risk based on achievement of performance goals, and increasing the certainty of 4-star or higher performance measurement is crucial to the stability of these programs. VIVA does not believe instituting these measures would decrease a plan's incentive toward continuous improvement, as the improvement measure methodology is a significant incentive toward that goal.

VIVA additionally requests that CMS improve transparency in national performance of display measures by calculating and publishing individual measure cutpoints instead of national averages. This would allow plans to better benchmark their own performance level against the nation and set more meaningful quality improvement goals.

VIVA agrees with the CMS proposal to hold harmless measures that maintain a 5-star rating but fall in numeric value year over year.

Measure Weights

VIVA does not support increasing the weight of survey-based measures. These measures are more subjective and less reliable than other star measures due to variability in samples from year

to year. These measures are also the least actionable due to plans' inability to identify the members surveyed, recreate the results, and apply meaningful performance improvement tactics to impact them. Questions that rate direct health care provider performance should be removed from consideration for health plan star measures or, at a minimum, moved to the display page. For example, the "Getting Appointments and Care Quickly" star measure contains the question, "In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?" These types of questions are not under the reasonable control of the health plan and do not reflect health plan performance. They would be more appropriately applied to a physician quality measurement/performance program. CMS currently mandates MA plan network access standards and other provider network requirements aimed to ensure adequate provider support for a given population. VIVA proposes replacing direct health care provider performance with alternate measure(s) of provider-member access facilitation or provider network relations that are a more direct reflection of health plan performance.

Categorical Adjustment Index (CAI)

VIVA appreciates continued commitment and recognition of disparity in performance associated with socio-economic disparities. VIVA requests CMS revisit the proposed methodology for selecting measures for adjustment. Specifically, VIVA disagrees with the application of the median absolute difference between LIS/DE and non-LIS/DE of 5 percentage points or more. For some measures, a difference of much less than this may be very statistically significant. VIVA proposes a model similar to the performance improvement calculation when determining what % of within-contract performance difference is statistically significant. In our own data and data supplied by Acumen for the LIS/DE population, differences are most pronounced in all medication adherence measures and we request all of the adherence measures be included in the adjustment.

Plan Preview of Star Ratings

VIVA supports the continuation of the plan preview periods. We find that preview periods of at least four weeks are necessary to complete the validation process and communicate/resolve potential issues with the CMS support teams.

Thank you for inviting comments on the proposed rule. VIVA appreciates the opportunity to collaborate in the rulemaking process. If you have questions or require clarification of our comments, please feel free to contact me at nbeasley@uabmc.edu.

Sincerely,



Nancy Beasley, RN BSN JD
Director Performance Improvement