

# UPMC HEALTH PLAN

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Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

**Re: 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)**

UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division (collectively, "UPMC") are pleased to submit the following comments in response to the Centers for Medicare & Medicaid Services (CMS or the "Agency") proposed rule regarding Contract Year 2019 changes to the Medicare program, as published in the Federal Register on November 28, 2017 (the "Proposed Rule").

UPMC is pleased to offer a full range of commercial individual and group health insurance, Medicare Advantage (MA), Medicare Special Needs Plans (SNPs), CHIP, Medicaid, behavioral health, dental, vision, employee assistance and workers' compensation coverage products. Our MA Plan, *UPMC for Life*, serves approximately 160,000 members combined through the MA Part C/D and SNP programs; more than 21,000 of these members are enrolled in *UPMC for Life Dual*, the largest stand-alone 4-star D-SNP in the nation. Through our Medicaid managed care organization, *UPMC for You*, we provide coverage to more than 400,000 enrollees across 40 Pennsylvania counties, and our behavioral health managed care organization, Community Care Behavioral Health, manages mental health and substance abuse services for almost one million Medical Assistance enrollees in Pennsylvania. UPMC also recently began enrolling members through Pennsylvania's Community HealthChoices, a Managed Long-Term Services and Supports (MLTSS) program that is expected to serve more than 360,000 individuals who are disabled, placed in nursing homes, or dually

eligible for Medicare and Medicaid. Collectively, our commercial and government programs membership exceeds 3 million.

We thank CMS for affording Medicare Advantage Organizations (MAOs) and other stakeholders an opportunity to comment on possible future changes to the MA and Part D program(s). UPMC supports CMS in its ongoing efforts to improve the quality, integrity, and efficiency of the Medicare program for all beneficiaries, while also ensuring that Medicare payment policies and administrative requirements continue to support the innovation and quality improvement long advanced by MAOs. It is with this support in mind that we respectfully offer for your consideration the following comments.

#### **A. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability**

##### **2. Flexibility in the Medicare Advantage Uniformity Requirements**

The Proposed Rule would establish a limited exception to the long-standing “Uniformity Requirements” in the MA program by allowing sponsors to vary, subject to certain protections, cost sharing for certain covered benefits, available supplemental benefits, and applicable deductibles for enrollees that meet specific medical criteria. We believe that this allowance represents a welcome change for many MAOs, and that it will significantly improve the ability of plans to offer coverage and benefits that best meet the diverse needs of the most vulnerable MA beneficiaries. We also support the Agency’s stated requirements regarding objective medical criteria and relationship of cost sharing reductions and benefits to a given disease condition; we agree with the Agency that these represent important protections against possible manipulation or misuse of the new exception to discourage or discriminate against certain vulnerable and higher-acuity beneficiaries. We respectfully encourage the Agency to adopt in final rulemaking the new exception to MA Uniformity Requirements as described in the Proposed Rule.

##### **3. Segment Benefits Flexibility**

The Proposed Rule would also newly permit MAOs to vary supplemental benefits (in addition to existing variability in premiums and cost-sharing) by service area Segment, subject to uniformity throughout any given Segment. We believe that this new flexibility will improve the ability of MAOs to design plans with targeted benefits that better serve beneficiaries’ needs. These targeted supplemental benefits will help support higher quality, improved health outcomes, and a better beneficiary experience in rural counties or other areas with limited dental and vision provider concentration, or where a regional population has a higher incidence of a particular chronic disease. We respectfully encourage the Agency to adopt the proposed benefits flexibility by Segment in final rulemaking.

## 5. Cost Sharing Limits for Medicare Parts A and B Services

The Agency proposes to modify its approach to testing for discriminatory cost sharing limits by incorporating MA encounter data, rather than FFS data, into patient utilization scenarios. This approach is more closely aligned with the discrimination testing performed for Qualified Health Plans under the ACA, and agree with the Agency that encounter data is likely more relevant and appropriate for this purpose than FFS data. We also appreciate and support the Agency's commitment to continue publishing and soliciting feedback, via the Call Letter and Health Plan Management System, information about the discrimination testing methodology; an important process that supports the ability of MAOs to appropriately design plans and set bid parameters. We remain concerned, however, about the degree to which a change from FFS to encounter data could impact discrimination testing thresholds in the first year. To avoid making a significant and unexpected year-over-year change to the discriminatory thresholds, which may unduly complicate MAOs' plan design process in the context of all other 2019 changes, we believe that the use of a two-year blended phase-in approach may be appropriate. We respectfully encourage the Agency to incorporate encounter data into patient utilization scenarios as proposed, but to phase in this change by blending FFS and encounter data for the stated purpose in 2019 and 2020.

## 6. Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review

The Proposed Rule would eliminate "meaningful difference" standards currently applicable to MAO plan bids. We support providing Medicare beneficiaries with a variety of coverage options from which to choose, but do not believe that MAOs are significantly constrained in plan design variety or innovation due to the current meaningful difference standards. While each beneficiary's needs and shopping experience are necessarily somewhat unique, modern psychological research continues to strongly suggest that an ever-increasing number of choices, particularly among complex products (e.g., health insurance with a range of cost-sharing, network, and other parameters), is in fact a disservice to consumers, whose decision-making ability is hampered by "choice overload" (see Chernev et al., *Choice overload* (Journal of Consumer Psychology 25,2 (2015))). Rather than encouraging innovation and beneficiary satisfaction, we believe that the elimination of meaningful difference rules may inadvertently promote dysfunction in the MA program by further exacerbating seniors' frustration with the plan selection process, and may create perverse incentives for MAOs in some regions to "flood" the market with innumerable plan designs that have only minor or inconsequential differences; such a result is a material barrier to informed choice among beneficiaries. In addition, the important segment- and uniformity-based benefit flexibility that the Agency has otherwise proposed for 2019 is already likely to drive significant innovation and increasing use of appropriately tailored benefit designs, the combination of which will dilute any perceived value of ending current meaningful difference limitations.

In lieu of eliminating meaningful difference standards, we respectfully recommend that the Department: (i) formally survey MAOs regarding whether and how meaningful difference rules functionally limit their product offerings, (ii) survey recently enrolled beneficiaries regarding their satisfaction with product variety in the MA program, and (iii) propose adjustments, if any, for 2020 or later based on the results of such surveys. If CMS nonetheless believes that immediate action is necessary to expand the limits of current plan design standards, we strongly encourage the Agency to modify, rather than eliminate, meaningful difference standards by adjusting the applicable threshold from \$20 to \$10; this will increase plan flexibility in the short term while still mitigating the adverse market and beneficiary impact described in the foregoing, until such time as the Agency is able to gather comprehensive feedback from beneficiaries and other stakeholders.

## 7. Coordination of Enrollment and Disenrollment Through MA Organizations and Effective Dates of Coverage and Change of Coverage

Among a number of changes to “default enrollment” rules, the Agency proposes new allowances for seamless MA enrollment of a plan sponsor’s non-MA members (e.g., commercial, Medicaid) upon their initial Medicare eligibility (“seamless conversion”). As the Agency notes, seamless conversion from Medicaid is in some respects administratively easier than that for commercial members, and is for a variety of reasons appropriately subject to unique requirements, particularly for D-SNP conversions. To date, MA plans have had limited flexibility in facilitating seamless conversion for their commercial members; the Proposed Rule would establish a new “opt-in” process for these members, and would allow MA plans to accept enrollment requests throughout a beneficiary’s Initial Coverage Election Period. We thank the Agency for recognizing the value of increased flexibility in seamless conversion for commercial members. We believe that the proposed opt-in process and longer enrollment window will allow plans to better serve their commercial members that are newly eligible for Medicare, while still appropriately addressing the Agency’s stated concerns regarding beneficiary dissatisfaction with seamless conversion in the past. We respectfully encourage the Agency to adopt in final rulemaking its seamless conversion proposal for plans’ commercial members.

## 11. Medicare Advantage and Part D Prescription Drug Program Quality Rating System

### *a. Introduction and Background*

We appreciate the Agency’s comprehensive articulation of both the history of the Star Ratings System and the guiding principles that the Agency uses when considering changes to that System. We believe that the comprehensive CMS Quality Strategy appropriately reflects the importance and value of a Quality Rating System for all stakeholders, and also acknowledges the challenges of measuring and rating quality across diverse domains and populations in practice. As a long-standing issuer in the MA program, we welcome the opportunity to participate in the Agency’s ongoing efforts to continuously improve and evolve the Star Ratings System to provide value for all stakeholders. To this end, we offer the following brief responses to

the Agency's various requests for input regarding how well the existing stars measures create meaningful quality improvement incentives and differentiate plans based on quality:

i. *Additional opportunities to improve measures so that they further reflect the quality of health outcomes under the rated plans.*

As a general principle, we recommend that the Agency continue to place emphasis on patient-reported and functional outcomes measures, and refrain from assigning undue weight to, or broadly focusing on increased incorporation of, other types of measures. We believe that the foregoing types of measures are among the most reliably reflective of beneficiaries' concept of plan quality, and that beneficiaries find these measures to be inherently more relatable and understandable when shopping for plans and considering Star Ratings.

ii. *Whether CMS' current process for establishing the cut points for Star Rating can be simplified, and if the relative performance as reflected by the existing cut points accurately reflects plan quality.*

We are concerned that the current "one size fits all" approach to cut points inaccurately reflects the real-world comparability of quality and performance between plans with appreciably different levels of enrollment. Plan quality strategies can vary significantly, and therefore beneficiary experiences can vary significantly, between smaller, often newer plans and much larger, often well-established plans. While no single strategy or experience may be decidedly better than all others, very small and very large plans are necessarily different in their approach to, and ability to adopt certain strategies for, improving quality. Under current rules, these very different quality programs and beneficiary experiences are nonetheless compared directly against one another; this impairs the overall informational value of some measures and, by extension, the reliability of their component function in the Star Ratings System. To mitigate these impacts, we encourage the Agency to consider establishing different cut points based on plans' enrollment volume; classifying plans as, e.g., small, medium, or large, before establishing cut points will help to ensure that relative plan performance is not skewed by being compared against the results of a much larger or much smaller plan.

iii. *Additional adjustments to the Star Ratings measures or methodology that could further account for unique geographic and provider market characteristics that affect performance (for example, rural geographies or monopolistic provider geographies), and the operational difficulties that plans could experience if such adjustments were adopted.*

While we appreciate the Agency's desire to tailor the Star Ratings System to account for the foregoing external factors that may affect plan performance, we are concerned that many external factors, and the identified factors in particular, are both difficult to objectively quantify and subject to significant variability. In lieu of establishing any new "external factor" measure adjustments or methodologies, we would respectfully encourage the Agency to consider refining its overall approach to plan geography by, for example, evaluating the extent to which plans with a multi-state geography may be given Star Ratings that fail to accurately reflect the differences in plan performance between States.

iv. *Adding measures that evaluate quality from the perspective of adopting new technology (for example, the percent of beneficiaries enrolled through online brokers or the use of telemedicine) or improving the*

*ease, simplicity, and satisfaction of the beneficiary experience in a plan.*

We support the Agency's interest in evaluating a plan's adoption and meaningful implementation of new technology to support beneficiaries both during and after the plan selection and enrollment process. As a Plan that has adopted numerous advanced technologies and long advocated for the inclusion of expanded telemedicine benefits in Medicare, we support consumers' continued access to advanced care and the technology that facilitates its delivery. That said, we are concerned that a host of factors, including those as simple as beneficiary preference, can significantly impact the rate of use for new technology or other plan enhancements. In addition, varying plan approaches to technology and information systems make objective comparison particularly difficult, and the concept of "new technology" is itself challengingly amorphous to capture in any definitional measurement. While we believe that some information about online resources and electronic or remote access technology may be of interest to beneficiaries, we do not believe that the Star Ratings System is the appropriate mechanism for collecting or displaying such information. We respectfully discourage the Agency from attempting to establish a measure of plans' technology adoption and/or beneficiaries' use of the same.

v. *Including survey measures of physicians' experiences*

The Proposed Rule seeks input on possible adoption of a survey tool to capture information on physicians' experience with MA plans. While we greatly value our relationships with providers and take very seriously their thoughts and feedback regarding interactions with our plan, we are concerned about the extent to which aspects of their assessments may be necessarily contingent upon factors unrelated to plan quality, and may thereby make the proposed survey unsuitable for inclusion in the Star Ratings program. As the Agency notes, physicians interact with plans on a daily basis, but in many cases this plan interaction occurs with other office staff; for physicians working in a hospital or other facility, most plan communication may be handled by shared, centralized staff of a larger patient unit. In addition to this complicating diversity of actors, provider satisfaction with a plan may be impacted by a range of factors that have no clear relationship to plan quality. Examples of these issues include contract disputes, issues with other plan products (e.g., commercial insurance), chart and billing audits, plan reimbursement levels, and local market dynamics that impact provider practices as business entities. Given these and other complexities of plan-provider relationships, we are concerned about the degree to which a survey of physician satisfaction may be impacted by business and contracting-related concerns that are well outside the scope of quality as measured by the Star Ratings program. As stated in the Agency's description of Star Ratings guiding principles, ratings should be "a true reflection of plan quality and enrollee experience," and improvement on measures should be "under the control of the health or the drug plan." While some objective measurements of physician-plan interaction (e.g., access to plans' provider services team) *could* be reliably collected as demonstrable elements of plan behavior, we do not believe that the concept of "physician experience" is fundamentally aligned with the foregoing principles, and we do not see a survey of physician experience as an appropriate proxy for measuring or evaluating the plan beneficiary experience. We respectfully recommend that the Agency refrain from adopting any "physician experience" measures or surveys at this time.

vi. *Health Outcomes Survey*

While the Proposed Rule does not include any significant methodological changes to the Medicare Health Outcomes Survey (HOS), we encourage the Agency to consider two possible adjustments to

improve the accuracy of the HOS and comparability of HOS results between plans. First, we have observed that plans with lower membership generally score higher on HOS measures than plans with significantly higher enrollment. While patient-reported outcomes are necessarily influenced by subjective judgments, we suspect that patients may have greater expectations for outcomes when they are enrolled in larger, well-established, and/or familiar plans. Though counter intuitive, popular high quality plans may lag behind in current HOS results because of factors like past positive beneficiary experiences, positive recommendations from personal contacts, or a sense that plans with a higher Star Rating will support a better or more satisfying outcome in the absolute. In order to account for this phenomenon, we encourage the Agency to consider balancing HOS results by incorporating an enrollment-weighted factor and/or a “perception factor” that considers, for example, the number of consecutive years a plan has maintained a 4-star rating. Second, we note that HOS questions about improvement in physical and mental health do not consider the natural aging process, and members in a survey cohort are two years older when they are re-surveyed. We recommend that the Agency engage stakeholders regarding appropriate mechanisms to control for the effects of aging while still maintaining appropriate balance in HOS results.

*e. Contract Ratings*

The Proposed Rule seeks feedback on the possibility of plan (PBP) level, rather than contract level, Star ratings, and specifically “whether changing the level at which ratings are calculated and reported better serves beneficiaries and our goals for the Star Ratings System.” As the Agency accurately notes, moving to plan level rating raises issues of small sample sizes that result in non-ratings, measure reliability, and significant increases in administrative burden for plans. We agree with the Agency’s assessment, and are additionally concerned that the limited diversity of population characteristics within a given PBP may not be illustrative of a beneficiary’s likely experience. Moreover, even with PBP enrollment above current reporting thresholds, smaller PBPs could be subject to significant rating variation year over year due to modest changes in enrollee characteristics, even if the level and effectiveness of the MAO’s quality program is not in fact materially different. In light of the Agency’s assessment and the foregoing additional concerns, we believe that the current contract level approach strikes an appropriate balance between precision and actionable information for beneficiaries.

*f. Contract Consolidations*

In lieu of current practice for contract consolidations, which adopts the Star Rating of the “surviving contract” regardless of the consolidating contracts’ relative enrollment size, the Proposed Rule would apply enrollment-weighted scores of both the surviving and consumed contracts for the first two years following a consolidation. We agree with the Agency that this approach will help to avoid situations where lower-quality contracts not otherwise eligible for a Quality Bonus Payment (QBP) nonetheless receive QBPs for their enrollees following consolidation with an often smaller, higher-quality plan eligible for QBPs. Such a situation not only costs the Medicare program more through the distribution of unearned QBPs, it also potentially misleads beneficiaries regarding actual plan quality. We believe that this scenario is most likely to occur with plans that are already under a common parent; between diverse parents, a surviving contract is more likely to be aligned with the new parent’s actual quality program and results, and existing

prohibitions on the transfer of contract H-numbers largely forecloses the possibility of gaming in such a transaction. We recommend that the Agency adopt in final rulemaking its proposed approach to consolidated contract ratings when consumed and surviving contracts are under the same parent prior to consolidation.

#### 14. Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes

The Proposed Rule would permit plan sponsors to immediately substitute newly released generic drugs for brand drugs, and to make related formulary tier and cost-sharing adjustments designed to encourage use of generic drugs by Part D enrollees; timelines for related advance beneficiary notices would also be reduced from 60 days to 30 days or, in the case of therapeutically equivalent generic substitution, eliminated in favor of notice concurrent with implementation. While we always support the provision of advance notice and additional beneficiary support regarding plan and policy changes whenever possible, the increasingly challenging prescription drug landscape means that even the best contingency planning can be disrupted by drug shortages or dramatic price fluctuation. In these types of scenarios, the launch of a new generic drug can materially alter an otherwise undesirable financial or clinical trajectory; an allowance for expedited generic substitution is an important tool that will ultimately allow plans to better serve beneficiaries and continue offering affordable plans of the highest quality. We appreciate the Agency's efforts to balance its proposed flexibility with adequate beneficiary protections, and we believe that the Proposed Rule achieves this end. We encourage the Agency to adopt its proposed generic substitution policy in final rulemaking.

### **B. Improving the CMS Customer Experience**

#### 2. Reducing the Burden of the Compliance Program Training Requirements

The Proposed Rule would eliminate requirements that MAOs' first-tier, downstream, and related (FDR) entities complete standardized CMS compliance training, and would no longer affirmatively require MAOs to provide compliance training to their FDRs. We agree with the Agency that increasingly sophisticated and robust MAO compliance programs have obviated the need for CMS to prescribe a specific approach to FDR training and oversight. The proposed approach will afford MAOs and their FDRs welcome flexibility in their satisfaction of the MA program's other long-standing compliance requirements, and we encourage the Agency to adopt its proposal in final rulemaking.

#### 4. Revisions to Timing and Method of Disclosure Requirements

The Proposed Rule would change plan disclosure deadlines for Explanation of Coverage (EOC), provider directory, and formulary documents from 15 days before the Annual Election Period (AEP) to the first day of AEP. We agree with the Agency's observation that beneficiaries already receive a large volume of information prior to AEP, and that the Annual Notice of Change (ANOC) is the most relevant and informative plan document for many beneficiaries. We do not believe that the historical advance distribution of plan documents other than the ANOC is necessary to support beneficiaries' informed enrollment decisions, and expect that both beneficiaries and plans will welcome the reduced volume of concurrent information associated with a slightly later plan document distribution. We support the Agency's proposed revision of EOC, provider directory, and formulary distribution deadlines.

The Proposed Rule would also modify historical requirements for the delivery of hard copy plan materials regardless of any beneficiary preference for electronic materials. As proposed, CMS will have flexibility to identify certain plan documents that plans may provide in hard copy only "upon request" when electronic versions are also made available. We believe that this policy will provide welcome relief for both plans and beneficiaries who currently send and receive, respectively, a large volume of printed materials, and will better serve those beneficiaries who would prefer to access most plan documents electronically. We respectfully encourage the Agency to adopt its proposed approach in final rulemaking.

#### 11. Part C/Medicare Advantage Cost Plan and PACE Preclusion List

The Proposed Rule would eliminate the current MA program enrollment requirement for providers and suppliers that furnish services to MA enrollees, and would instead establish a program Preclusion List that is updated on a monthly basis. As the Agency notes, the combination of Medicare enrollment and MAO credentialing is the most effective means of ensuring that providers are both compliant with MA program requirements and qualified to furnish services to MA enrollees. While we acknowledge and understand the Agency's desire to alleviate the administrative burden associated with MA enrollment by providers and suppliers, we are concerned that the elimination of this safeguard will merely transfer, rather than eliminate, the cited administrative burden. Plans are understandably cautious and thorough in their efforts to credential new MA providers. In the absence of MA program enrollment verification, MAOs will be denied a valuable and reliable data source when considering provider credentialing and network participation, and may need to invest additional resources in developing fraud, waste, and abuse (FWA) investigations. While already of great consequences, the loss of prospective MA review of providers will only make the nature of credentialing and FWA programs even more critical, and will create new incentives for plans to fill the oversight void left by the loss of MA program enrollment. As a result, the MA program at large is likely to see little or no reduction in total administrative burden; on the contrary, a diversity of efforts among plans seeking to compensate for the loss of enrollment data may in fact make program participation more burdensome for providers, who could be subject to new and unique review or verification requirements by plans. In light of the foregoing, we believe that the risks associated with elimination of current enrollment requirements outweigh any modest reduction to provider burden that may result. We respectfully encourage the Agency to maintain the current MA program enrollment requirement for providers and suppliers wishing to serve MA beneficiaries.

*National Provider Identifier (NPI) in Encounter Data Submissions*

In support of establishing the proposed Preclusion List, CMS proposes to amend existing Risk Adjustment data submission requirements to require the submission of provider NPIs as part of submitted encounter data. While we, as described in the foregoing section, oppose the use of a Preclusion List, we believe that attaching NPIs to encounter data is an appropriate means of promoting overall program integrity even in the absence of the proposed Preclusion List. As such, we support the Agency's amended requirements for Risk Adjustment data, but urge consideration of two related issues prior to final rulemaking. First, while standard claims transactions (which represent the vast majority of claims) include provider NPI data, a provider that submits a manual, paper claim may not have an NPI on file with the plan. While plans may engage in efforts to obtain an NPI, response to these efforts from an unaffiliated provider is not always timely. To provide for this uncommon but very real scenario, we recommend that the Agency adopt a limited exception to its proposed NPI requirement where a provider submits a paper claim and does not have an NPI on file with the receiving plan. Second, a number of providers, including rehabilitation centers and durable medical equipment (DME) suppliers, are contracted by and bill plans under a group or "Type 2" NPI. The Proposed Rule is not clear regarding whether CMS will accept a Type 2 NPI in satisfaction of the proposed encounter data standard. For plans that currently accept and use Type 2 NPIs, capturing individual NPIs would likely require changes to both credentialing policies and contracting standards; the administrative burden of making these changes would be considerable. While the use of exclusively Type 1 NPIs could represent a very significant burden for some plans, we do not believe that use of a Type 2 NPI would provide any less support for the Agency's program integrity efforts than that provided by a Type 1 NPI. We respectfully ask that final rulemaking provide allowances for submission of either Type 1 or Type 2 NPIs in Risk Adjustment encounter data.

We again thank the Agency for affording issuers and other stakeholders the opportunity to provide input on proposed changes to the Medicare Advantage and Part D program(s) for 2019. We appreciate your consideration of these comments and look forward to continued collaboration with CMS in the future.

Respectfully Submitted,



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UPMC Health Plan