



Jonathan Dinesman  
Senior Vice President, Government Relations  
Centene Corporation  
jdinesman@centene.com

March 5, 2018

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

**RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter**

Dear Administrator Verma,

Centene Corporation appreciates the opportunity to provide feedback on CMS' 2019 Advance Notice and draft Call Letter published December 27, 2017 (Part I) and February 1, 2018 (Part II).

Founded in 1984, Centene Corporation (hereinafter "Centene") has established itself as a national leader in the healthcare services field with over 12.2 million members across the country. Centene provides health plans through Medicaid, Medicare, and the Health Insurance Marketplace and other Health Solutions through our specialty services companies. Centene covers 243,000 Medicare Advantage (including Special Needs Plan) beneficiaries across 13 states, and 48,000 Medicare-Medicaid Plan (MMP) beneficiaries. For 2018, we have expanded our footprint into six additional states.

**INTRODUCTORY COMMENTS**

Before presenting detailed comments, Centene would like to highlight some specific important areas, some of which are directly related to the Notice and draft Call Letter while others are broader but would benefit the Medicare Advantage and Part D program as well:

- In the Medicare program, as well as in other areas, Centene has prided itself at providing health care access to the most vulnerable populations of our country, with focus on meeting the needs of our members with high-quality and affordable coverage. Our experience with these populations helps us to see the diversity of these groups and the importance of tailored interventions that optimize both medical care and social determinants of health. We have highlighted areas where we see positive changes or possible refinements related to serving vulnerable individuals or those who use and access health care differently (e.g. rural beneficiaries), including where additional flexibility could directly benefit care to our members.
- We are appreciative of CMS' willingness to provide additional flexibility as it relates to supplemental benefits in the Part C program. This will allow us to design benefit packages that better meet the needs of individuals with

chronic conditions or specific health needs and, we believe, will lead to an overall more efficient and effective use of health care resources.

- As it specifically concerns the dual-eligible population, this population particularly benefits the most from the enhanced care management and coordination associated with managed care. While CMS continues to make advancements in aligning Medicaid and Medicare through Special Needs Plans (SNPs) and the Financial Alignment Demonstrations, more can still be done to improve alignment and ensure that the incentive structure is such that plans are not penalized for serving a disproportionate share of high-needs, high-cost populations. In addition, the program must provide the necessary flexibility so plans can meet beneficiaries' needs in a way that leads to better outcomes long-term. Telehealth, in particular, has great potential for improving care and outcomes for these beneficiaries. Centene has included several comments that would address some of the existing issues and we look forward to working with CMS in the coming years to further improve the way in which public programs serve vulnerable populations.
- We are supportive of CMS' efforts to continue to refine the Star Ratings and encourage CMS to advance its efforts to reflect population differences among MCOs, particularly as they relate to accounting for low-income and dual eligible beneficiaries (although we still see deficits in the current Categorical Adjustment Index (CAI) approach); enhancing the overall reliability of measures included in the Star Ratings and on the display page; and looking, where possible, to reduce the overall quality reporting burden on plans by reconciling duplicative and overlapping measures. Additionally, consistent with CMS' past comments in the MA and Part D Call Letter and Payment Notice, Centene believes strongly that Star Ratings should be based on the most up to date information possible and operate under guidelines grounded in the ultimate goal of providing accurate and helpful information to beneficiaries relevant to their plan selection. Specifically, we applaud CMS' proposal to remove the exiting Beneficiary Access and Performance Problems (BAPP) measure from the 2019 Star Ratings and replace it with a measure that exclusively utilizes CAM measures. Consistent with these policies, and CMS' existing policy related to sanctioned plans, we recommend CMS remove CMP deductions from the BAPP calculation for 2019 QBPs so the influence of this policy change does not become a matter of timing.
- As CMS undertakes efforts to reduce regulatory burden, we also encourage the development of a common regulatory framework across federal health programs and within the same program (e.g., common framework amongst PACE, SNPs, etc.) to ensure they receive equal attention and are on a level playing field in terms of both requirements and payments. Many Medicare beneficiaries are covered not just by Medicare but also by Medicaid and/or a state LTSS program. In many instances, these programs have inconsistent or conflicting requirements, such that reducing regulatory burden in one program may not have the desired outcome as compliance is still required with the overlapping provision in another program. Where possible, we encourage CMS to create needed alignment with other federal health programs.
- Finally, as CMS takes steps to address the broader opioid crisis in this country we applaud the proposals in the draft call letter that will create better alignment and consistency among programs. We are actively working with our state Medicaid partners on solutions to this epidemic. Our strategic approach is designed for prevention, treatment and recovery. We work with our members and providers to prevent addiction from occurring by curbing excessive prescribing patterns, preventing overdoses and facilitating treatment and recovery in chronic opioid users. To this end we hope to contribute to future dialogue on this topic and share our experience.

Our specific comments are organized in the order that issues appear in the proposed rule:

## ATTACHMENT II. CHANGES IN THE PART C PAYMENT METHODOLOGY FOR CY 2019

### Section C. IME Phase Out (Page 22)

CMS proposes to continue its implementation of IME reduction for the 2019 rate book. CMS notes that PACE programs are excluded from the IME payment phase-out.

*Centene continues to advocate for a common statutory and regulatory framework, including financing, for all integrated plans (MA-SNP, MMP, DSNP, PACE, etc.), instead of maintaining exclusions and separate structures that unfairly advantage some integrated plans over others and reduce competition.*

### Section H. CMS-HCC Risk Adjustment Model for CY 2019 (Page 30)

On December 27, 2017, CMS published Part I of the Advance Notice for public comment which included proposed changes to the Part C risk adjustment model, including a proposal to move towards the “Payment HCC count model”

*Based on our review of this proposal, Centene recommends CMS’ change to adopt the Payment HCC count model. Our recommendation is based upon our review of the predictive ratios by decile that were provided by CMS where the Payment HCC count model consistently predicted costs more accurately than the All HCC count model. Nonetheless, we recognize that various versions of the Payment HCC count model were tested and each had tradeoffs and limitations; to this end we believe a more detailed conversation with stakeholders around additional model various would be beneficial to creating the best model. Furthermore, we recommend CMS remain open to fully implementing the Payment HCC count Model without linking it directly to the use of 100% EDPS data.*

*We also encourage CMS to revisit its decision to exclude dementia diagnoses from the list of HCC payment conditions. We believe, given the prevalence of dementia conditions and its effect on overall cost, this inclusion will dramatically increase the predictive power of the HCC model, especially for high-risk and vulnerable segments of the population.*

### Section J. Frailty Adjustment for PACE organizations and FIDE SNPs (Page 34)

Since CMS is proposing to implement the “Payment Condition Count” model in 2019, it is also proposing updated frailty factors based on this model. These frailty factors are included in the calculation that determines frailty scores for FIDE SNPs.

*Centene continues to advocate for a common statutory and regulatory framework for all integrated plans (MA-SNP, MMP, DSNP, PACE, etc.), instead of maintaining exclusions and separate structures that unfairly advantage some integrated plans over others and reduce competition. If frailty adjustments are available to PACE and FIDE-SNPs, then they should also be available to all integrated plans that primarily serve populations with complex care needs (which includes MMPs).*

### Section L. Normalization Factors (Page 36)

When a risk adjustment model predicts expenditures in future years, the average risk score for Original Medicare beneficiaries may no longer be 1.0 due to changes in coding and population characteristics. In payment year 2018, CMS returned to using a linear slope method of projecting normalization factors. CMS proposes to maintain this methodology for all models in payment year 2019.

*There appears to be a disconnect between the risk calibration model used for normalization and the underlying data using ICD-9 vs. ICD-10. Both the Payment HCC and All HCC count models are calibrated using ICD-9 diagnoses, while the scores generated for the calculation of the FFS normalization factors utilize ICD-10 diagnoses for a portion of 2015 and all of 2016-2017. Centene is concerned that the large increases in average risk scores in 2016 and 2017 which drive the normalization factor may be partially attributable to the conversion to ICD-10 and recommend CMS include additional years of data, or more heavily weight ICD-9 years, to dampen the impact. If the normalization factor is artificially high and not reflective of the true costs, the impact will ultimately decrease our ability to adequately serve the beneficiaries covered by our programs.*

#### **Section N. Encounter Data as a Diagnosis Source for 2019 (Page 42)**

CMS' proposal for use of encounter data for the CMS-HCC model was included in Part I of notice. This approach calls for 25% of the risk score to be calculated with encounter data aligned with the "Condition Count" HCC model, while 75% would be determined by RAPS and aligned with the 2017 model.

*Centene supports CMSs' goal to move to 100% encounter data based risk scores. However, we are concerned about the risk to Medicare Advantage Organizations and their beneficiaries if EDPS scores fail to converge with RAPS scores. We believe EDPS scores continue to be understated and request that CMS uphold their commitment to revenue neutrality between RAPS and EDPS. We are especially concerned that, if this understatement is not addressed, the effect by payment year 2022 (when CMS proposed to move to 100% encounter data) will be exacerbated.*

#### **Attachment VI. Draft CY 2019 Call Letter (Section I – Parts C and D)**

##### **New Measures for 2019 Star Ratings (Page 107)**

- ***Statin Use in Persons with Diabetes (SUPD) (Part D).*** This is a PQA measure. CMS proposes to add the SUPD measure to the 2019 Star Ratings (based on 2017 data) with a weight of 1 for the first year. In subsequent years, CMS proposes a weight of 3 as an intermediate outcome measure.

*Since this measure is not an index of adherence, but rather the number of members who were dispensed a statin medication during the measurement year, Centene recommends setting the weighting at 1 for the first and second years. We respectfully request CMS review the strategy for measuring Statin Use in persons with Diabetes and Cardiovascular disease and adopt a consistent strategy. SUPD uses PQA and SPD uses HEDIS technical specifications. If the intention is to measure a process, and, given the similarity of the two measures, we would propose using both HEDIS Measures SPD and SPC. We would like CMS to explain the rationale as to why two different methodologies (PQA and HEDIS) would be preferable to using the HEDIS methodologies.*

*Finally, we would ask CMS to work with measure developers to make sure the measure fully accounts for those beneficiaries with contraindications or intolerance to statins.*

- ***Statin Therapy for Patients with Cardiovascular Disease (Part C).*** This is an NCQA measure currently on the display page. CMS proposes to include this measure in the 2019 Star Ratings as a process measure with a weight of 1.

*Centene recommends leaving the weighting at 1. We respectfully request CMS review the verbiage on page 108 of the 2018 Draft Call Letter, which states "We propose to include this measure in the 2019 Star Ratings as a process measure with a weight of 1, as it is based on medical records review if medications were prescribed." As the HEDIS Technical Specifications indicated, SPD is calculated using administrative data only and there is no medical record review component to this measure.*

#### Changes to Measures for 2019 (Page 108)

- ***Improvement Measures (Part C and D).*** CMS proposes to update the improvement measure to include all those measures that can be validly trended.

*Centene suggests not adding any measures to the improvement measure for 2019 rating because of concerns around impacts to beneficiaries due to natural disasters. These measures could be reintroduced in the 2020 ratings.*

- ***Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications (Part D).*** For the 2017 measurement year, CMS proposes to expand its data sources for identifying all Part D enrollees with ESRD for exclusion from the measures.

*Centene agrees with expanding the data sources to identify all Part D enrollees with ESRD for exclusion from this measure.*

- ***Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D).*** CMS proposes joining consecutive stays to create a single admission and discharge date for the PDC adjustment.

*Centene agrees with concatenating consecutive stays to create a single admission and discharge date for the PDC adjustment.*

- ***MPF Price Accuracy (Part D).*** CMS is proposing enhancements to the MPF Price Accuracy measure to better measure the reliability of a contract's MPF advertised prices.

*Centene supports CMS in modeling the improvements to the MPF measure as a display measure in 2020 and 2021; and strongly agrees that the current version of the measure should be retained since in its current form it still provides valuable information to beneficiaries.*

- ***Members Choosing to Leave the Plan (Part C & D).*** CMS proposes to expand the exclusions for this existing measure to include plan benefit package (PBP) service area reductions (SARs) that result in the unavailability of PBPs that the enrollee is eligible to move to within the contract.

*Centene supports expanding the exclusions for this measure to include plan benefit package (PBP) service area reductions (SARs) that result in the unavailability of PBPs that the enrollee is eligible to move to within the contract but would request an impact analysis of these changes based on a prior year's performance results. We also request CMS add new Transaction Reply Codes (TRCs) in order for plans to be able to track this impact throughout the measurement year.*

*In addition to these proposed exclusions, Centene would also recommend excluding instances where a member switches enrollment from one contract to another under the same Parent Organization. Cross-contract enrollment changes under the same legal entity may be the result of intentional cross-walking to provide greater continuity of care and is not generally due to member dissatisfaction.*

- **SNP Care Management**

*While CMS is not proposing any changes to this measure for 2019, Centene believes the specifications for SNP Care Management HRA's (Health Risk Assessments) remain overly complicated. As a simpler alternative to the counting requirements, CMS could measure the percentage of members who are eligible at least 90 days with the plan who receive an assessment during the calendar year, similar to the way HEDIS would measure a screening that was required annually. This would vastly simplify counting and processes. Health plans currently must shorten the assessment window to 9 months or even 6 months in order to beat the 365-day countdown in cases where a member travels or is unresponsive for periods of time. This is a de facto form of overutilization. A "calendar year" requirement would largely solve this issue as well. The number of assessments required over time would remain largely the same under this simplified structure. We also would encourage this extending this policy to qualified non-FIDE SNPs.*

## Removal from Star Ratings (Page 112)

- **Beneficiary Access and Performance Problems (BAPP) (Part C & D).** For the 2019 Star Ratings, CMS proposes to retire the current BAPP measure. CMS proposes to modify the BAPP measure to only include Compliance Activity Module (CAM) data.

*Centene supports moving the BAPP measure to the Display Page in the 2019 Ratings and de-coupling sanctions and CMPs from data collected through the Compliance Activity Module (CAM). We feel that data captured through the CAM already provides a well-documented and robust way of tracking operational compliance. Integrating potential CMPs and sanction outcomes into the BAPP measure not only has the potential to result in compounding penalties, but also fails to recognize the potential severity of any issues uncovered in a program audit (i.e. CMP amount, beneficiary impact, size of contract, etc.).*

*Additionally, as CMS has acknowledged, including CMPs as part of the BAPP does not create alignment in penalties, but unnecessary variation in outcomes based on timing of audits, a particular year's star rating measure methodology, and performance on other Star Rating measures. Thus, to maintain consistency and fairness across plans and over time, we request that CMS address not only the BAPP policy for 2019 Star Ratings, but address the effect this policy has had on 2019 QBP determinations (based on 2018 Star Ratings). Consistent with these policies, and CMS' existing policy related to sanctioned plans, we recommend CMS remove CMP deductions from the BAPP calculation for 2019 QBPs so the influence of this policy change does not become a matter of timing.*

## Temporary Removal from Star Ratings (Page 113)

- **Reducing the Risk of Falling (Part C).** NCQA has made significant revisions to the questions related to this measure on the HOS survey. The revised questions will be first collected in 2018. As a result of this timing, there will be no data for this measure for the 2019 Star Ratings. CMS proposes to add it to the 2020 display page and intends to add it for the 2021 Star Ratings.

*Centene supports the proposed temporary removal of the Part C Fall Screening Measure due to NCQA changes to the measure; and agrees with this measure being on the display page in 2020 and its inclusion in 2021 Star Ratings. If further revisions to the measure are made, Centene recommends adding all beneficiaries, regardless of age, to the denominator (which currently includes beneficiaries age 65 and older). All beneficiaries with a history of falls, or who have a disability that predisposes them to falls (e.g. vestibular disease, diabetes, COPD, etc.) should be screened, regardless of age.*

## Data Integrity (Page 113)

CMS is proposing scaled reductions for Appeals IRE Data Completeness Issues. For verification and validation of the Part C and D appeals measures, CMS has relied primarily on the use of audit findings and targeted reviews. Contracts identified during an audit review to have systematic issues with the completeness of the IRE data have had their appeals measures reduced to one star. In response to stakeholder concerns, CMS initiated the Timeliness Monitoring Project (TMP) in CY 2017. The proposed change would apply a scaled reduction to the measure-level Star Rating for the applicable appeals measures.

*Centene supports CMS' efforts to ensure the accuracy and completeness of the IRE data through the Timeliness Monitoring Project (TMP) and believe that employing the statistical criteria laid out in the Advance Notice is a fair and appropriate way of making graduated adjustments based on a contract's potential error rate. We would also like to see an impact analysis of the proposed changes based on the most recent TMP.*

*Furthermore, we request that this process of scaled reduction for non-systemic issues be applied throughout the Star Ratings where appropriate. In particular, technical specifications and guidance on the SNP Care Management measure have been inconsistent. Auditors often contradict CMS interpretation of specifications and/or CMS has provided conflicting guidance when approached with the same clarification. Until this issue can be addressed, we suggest that the measure (SNP Care Management) be retired (for 2019 rating). Once the measure is reintroduced cut points should be stratified based on SNP Type as I, C, and D-SNPs all have different outcomes on this measure.*

*Lastly, we would propose that CMS develop a hold harmless provision when measures are removed due to an error on the part of CMS or its third-party business partners. Medicare Advantage Organizations should not suffer reductions in Star Ratings due to unforeseen circumstances related to data integrity.*

## 2019 Star Ratings Program and the Categorical Adjustment Index (CAI) (Page 122)

For the 2019 Star Ratings Program, CMS is proposing to continue the use of the interim analytical adjustment, the CAI. The overall methodology would remain unchanged for 2019. CMS has also indicated that it is actively engaging with a measure steward to test the feasibility of measure-level risk-adjustment.

*Centene requests that CMS reevaluate the CAI as it is insufficient to provide true differentiation and meaningful adjustment. Plans who serve LIS/DSNP populations continue to be disadvantaged by the current methodology. The small number of plans who received benefit from the CAI for the 2018 rating is indicative of the need for a more meaningful adjustment. Additionally, CMS must account for between plans differences which are not the result of true performance differences but rather the result of more complex underlying social determinants which contribute to disparities in outcomes. Research strongly supports the effect of the local economy (e.g., access to jobs, schools, transportation, fresh produce, cost of living) on the health of the people living in that neighborhood.<sup>1</sup> Therefore, it is specious to assume that outcomes for DSNPs/LIS, for example, in rural areas are homogenous with DSNPs in metropolitan areas.*

*Specifically, we believe that providing an adjustment only when a difference of 5 percentage points or more exists is arbitrary. Differences should be based on statistically significant differences between LIS/DE and non-LIS/DE populations and account for member specific characteristics. Furthermore, CMS should increase the offset provided by the CAI to provide immediate relief to plans who serve these sensitive populations.*

## Disaster Implications (Page 133)

CMS is considering a variety of strategies to address Star Ratings issues related to contracts impacted by extreme and uncontrollable circumstances. CMS proposes to adjust the 2019 and 2020 Star Ratings to take into account the effects of extreme and uncontrollable circumstances that occurred during the performance period, such as the disasters (Hurricanes Harvey, Irma, and Maria, and the wildfires in California) that occurred during the 2017 performance period. CMS proposes processes for identification of affected contracts, and adjustments for CAHPS, HOS, HEDIS, and other Star Ratings Measure Adjustments. CMS also proposes to remove affected contracts from the cut-point clustering methodology and reward factor thresholds.

*Rather than assuming that the measure-level scores for contracts with very few enrollees impacted should not be adversely affected by these disasters, Centene would request that CMS provide an approach that would account for any disadvantage. Contracts with any beneficiaries residing in affected Individual Assistance areas at the time of the disaster should receive the higher of the 2018 or the adjusted 2019 Star Ratings (and corresponding measure ratings) for each CAHPS measure (including the annual flu vaccine measure). Since the cut points for the CAHPS measures are so tightly compressed, CMS should provide plans the benefit of the doubt given the unique circumstances faced in 2017. (For CAHPS and HOS).*

*Specifically, applying a cutoff of 25% of members affected seems arbitrary especially given that small changes in rates (1-2%) year over year could impact the improvement measure. CMS should provide a more nuanced approach which*

---

<sup>1</sup> Woolf, S.H., Aron, L., Dubay, L. et al (April 2015). How Are Income and Wealth Linked to Health and Longevity? Income and Health Initiative (Brief No. 1). Retrieved from <https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf>; Gaskind, DJ, Thorpe, RJ, McGinty, EE, et al. Disparities in Diabetes: The Nexus of Race, Poverty, and Place. Am J Public Health. 2014; 104:2147-2155; State of the States: The Poverty and Inequality Report. Pathways (Special Issue: 2015) [https://inequality.stanford.edu/sites/default/files/SOTU\\_2015.pdf](https://inequality.stanford.edu/sites/default/files/SOTU_2015.pdf).



*provides relief for all plans based on the proportion of members likely impacted. It is reasonable to assume that contracts with less than 25% of beneficiaries in IA may be adversely impacted.*

## 2019 CMS Display Measures (Page 140)

- **Hospitalizations for Potentially Preventable Complications (Part C)**

*Centene agrees with retaining this as a 2019 Star Display measure; and with moving it to the Star Ratings in 2022 with a weight of 1 Star. We also recommend leaving it at a weighting of 1 for a minimum of 2 years prior to increasing the weight to a 3 Star. NCQA must demonstrate that the risk adjustment methodology they have employed accounts for disparities in addition to the HCC related risk adjustment they already employ. Plans who serve underserved communities or populations with higher disparities in health outcomes, may otherwise be disadvantaged on this measure.*

- **High Risk Medication (Part D)**

*Centene agrees with retaining this as a 2019 Display measure.*

- **Drug-Drug Interactions (DDI) (Part D)**

*Centene agrees with implementing the revised list for the 2019 display measure using 2017 performance and PDE data.*

- **Antipsychotic Use in Persons with Dementia (APD) (Part D)**

*Centene agrees with retaining this measure as a 2019 Display measure with the overall rate and the population break out rates between community only and long-term nursing home residents.*

- **Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D)**

*Centene agrees with utilizing Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP) as it aligns with the criteria used in the Overutilization Monitoring System.*

- **Appropriate Monitoring of Patients Taking Long-term Medications and Asthma Medication Ratio (Part C)**

*Centene agrees with removing these from 2019 Display Measure due to removal by NCQA of the Medicare population by NCQA.*

## Potential Changes to Existing Measures (Page 145)

- **Controlling High Blood Pressure (Part C).** NCQA is evaluating potential updates to the Controlling High Blood Pressure measure for HEDIS 2019. Additionally, NCQA is exploring modifications to the denominator criteria of the measure to improve feasibility and reduce burden, and potential administrative approaches for meeting numerator criteria.

*Centene agrees with potential updates to this measure since the guidelines for hypertension have changed from  $\geq 140/90$  to anyone with a systolic blood pressure  $>130$  or a diastolic blood pressure  $>80$ . We look forward to*

*learning of the modifications to both the denominator and numerator. As further facilitation of these results, we would recommend CMS revise the fee schedules to include reimbursement for CPTII coding to capture blood pressure readings.*

- **Plan All-Cause Readmissions (Part C).** NCQA is exploring several revisions to the HEDIS Plan All-Cause Readmissions that may impact the definition of the denominator, numerator, and risk adjustment model for data collected in 2018. NCQA is also considering stratifying this measure to separate those individuals with high frequency of index hospital stays as well as a possible stratification of the Plan All-Cause Readmissions measure to identify the percentage of hospital discharges that result in an unplanned hospital readmission during or after a skilled nursing facility stay for MA contracts.

*Centene agrees with a combination of monitoring, having the current PCR remaining in the Star Ratings until 2020 or beyond while simultaneously having the proposed new Plan All Cause Readmission on Display. Of the changes proposed, we agree with NCQA's recommendation to revise the minimum number of events to 150 for the denominator. We applaud the inclusion of observations stays in the numerator and denominator as well as revising the denominator to be the overall plan population as opposed to indexed hospital admissions. We look forward to being able to respond to the proposed changes regarding the inclusion of death, as at this time there is not enough information provided in the call letter to provide feedback on that aspect of the measure and we are interested in determining how the measure will differentiate between terminal end of life deaths versus unexpected member demise. Furthermore, we feel that combining all ages in the proposed measure for Star ratings would provide a better picture of the plan's performance rather than just including 65+ and older. Lastly, we feel there is value in a separate measure to identify the hospital readmissions from skilled nursing facilities.*

- **Initiation and Engagement in Alcohol or Drug Dependence (AOD) Treatment (Part C).** NCQA modified this measure to include data on the use of MAT in the denominator and numerator components of the measure. This measure will continue to be included on the display page.

*Centene agrees with continuation of this measure on the Stars Display page. We would respectfully ask for more context behind the potential diagnostic codes of self-harm, asphyxiation, overdose, and poisoning as we would want the codes to accurately represent true behavioral health diagnosis.*

- **Telehealth and Remote Access Technologies (Part C).**

*Centene applauds CMS for seeking feedback on the appropriateness of including telehealth and/or remote access technology encounters with regard to the following measures:*

- *Adults Access to Preventive/Ambulatory Health Services.*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
- *Controlling High Blood Pressure*
- *Comprehensive Diabetes Care*

*Further information is needed to determine the burden of cost for remote monitoring, but overall, we feel the use of remote monitoring will be beneficial in meeting the needs of underserved populations.*

- **Cross-Cutting Exclusions for Advanced Illness (Part C).** NCQA is evaluating the clinical appropriateness and feasibility of excluding individuals with advanced illness from selected HEDIS measures. This includes what specific illnesses and healthcare utilization may warrant an exclusion, and to which measures the exclusion should be applied.

*Centene agrees with evaluating the clinical appropriateness and feasibility for excluding individuals with advance illness from selected HEDIS measures and looks forward to additional guidance from NCQA on which specific illness and measures would include exclusions. Centene generally supports the exclusion of individuals with advanced terminal illness from selected HEDIS measures but cautions against excluding all individuals with non-terminal advanced illness.*

- **Medication Adherence (ADH) for Cholesterol (Statins) (Part D).** PQA updated this measure for 2018 to exclude beneficiaries with ESRD.

*Centene agrees with applying the ESRD exclusion to the 2020 Star Ratings.*

- **Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D).** PQA updated this measure for 2018 to include a new denominator exception for not meeting continuous enrollment.

*Centene agrees with applying the continuous enrollment denominator exclusion to the CMR measure.*

#### Potential New Measures for 2020 and Beyond (Page 148)

- **Transitions of Care (Part C).** CMS plans to propose to include this measure with the four indicators on the 2020 display measure for possible inclusion in the 2022 Star Ratings.

*Centene agrees with inclusion of this measure with all four indicators on the 2020 display measure for possible inclusion in the 2022 Star Ratings. We respectfully request CMS provide guidance on how the Medication Reconciliation Post Discharge measure will be handled during this time period. We would request that NCQA align MRP/TRC measures with all other HEDIS measures, proposing the timeline shift that ends on 10/1/xx of the reporting year versus 12/1/xx, to allow for claims lag for readmissions to hit our system at the time plans draw HEDIS samples for hybrid pursuit.*

- **Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C).** CMS plans to propose to include this measure on the 2020 display page for possible inclusion in the 2022 Star Ratings.

*We applaud CMS and NCQA for the development of this measure, however, we would like to have further context on the chronic conditions that would be included in this measure and the ability to provide feedback on timing for inclusion in Star Ratings.*

- **Care Coordination Measures (Part C).** CMS has identified potential new care coordination measures and is currently testing them for possible future implementation and will provide more details at a later date.

*Centene is looking forward to the potential new care coordination measures. Reliance on surveys may not provide a true reflection on the level of work that is completed by a health plan to coordinate members care and look forward to providing additional feedback on measure specifications. We would recommend ensuring the appropriate provider types, i.e. physician, nurse, and plan staff can close this gap as we are concerned heavy reliance on physicians places an undue burden on physicians at a time when physician burnout is at all-time high. Additionally, we also would be interested in exploring with CMS and others other ways to capture this data.*

- **Opioid Overuse (Part C).** CMS is seeking feedback about the value of including these Part C measures on the display page, given the similar Part D measures that constitute data for Patient Safety reports back to plans and which may also be reported on the display page.

*Given the serious nature of the Opioid epidemic, Centene feels there is value in having these measures, but would need more information on the measure structure to provide feedback and how to weight the value in contrast to any burden from measurement in this area and looks forward to final definitions for "opioid naïve" and "chronic use" as well as the population that will be excluded.*

- **Assessment of Care for People with Multiple High-Risk Chronic Conditions (Part C)**

*This measure provides the opportunity to collect valuable information about, not only the care coordination provided by health plans, but assessment of Medicare beneficiaries by providers. Centene will look to NCQA, as measure steward, to create methodology for this measure that will not add burden to the health plan and will have the appropriate number of chronic conditions identified as sub-measures identified—allowing closure using documentation from a health plans' clinical documentation systems. Furthermore, if a health plan is already using the CMS/Mathematica MLTSS Comprehensive Assessment and Update measure currently being considered for NQF endorsement (NQF # 3319), health plans should be able to substitute that particular measure for the proposed Assessment of Care for People with Multiple High-Risk Chronic Conditions (Part C) measure.*

- **Depression Screening and Follow-Up for Adolescents and Adults (Part C)**

*Centene agrees that this measure should be placed on the Stars Display page in the future depending on results of the first year of implementation.*

- **Unhealthy Alcohol Use Screening and Follow-Up (Part C).**

*Centene agrees that this measure should be placed on the Stars Display page in the future depending on results of the first year of implementation.*

- **Readmissions from Post-Acute Care (Part C).** Being developed by NCQA for HEDIS 2019 with possible future inclusion in the Star Ratings.

*Centene welcomes the opportunity to provide feedback on this measure when additional information is provided by NCQA. It is difficult to provide feedback on the burden of such a modification/stratification of a new measure without being able to view the proposed technical specifications of the measure. We look forward to learning if CMS plans to monitor skilled nursing facilities on this metric as part of the Meaningful Measures Initiative which is part of Effective Communication and Care Coordination.*

- **Adult Immunization Measure (Part C).** Being developed by NCQA for HEDIS 2019 with possible future inclusion in the Star Ratings.

*Centene looks forward to reviewing the HEDIS 2019 technical specifications; it is difficult to provide feedback on the burden of the new measure without seeing the proposed technical specifications of the measure.*

- **Anxiety (Part C).** Potential NCQA HEDIS measure.

*Centene looks forward to reviewing the HEDIS 2020 technical specifications; it is difficult to provide feedback on the burden of the new measure without seeing the proposed technical specifications of the measure.*

## Measurement and Methodological Enhancements (Page 156)

CMS and measure developers are exploring additional measurement concepts for future work, such as functional status, and use of non-pharmacological or non-opioid pain management interventions, which will require use of non-claims data. Additionally, CMS is interested in new or enhanced measures for beneficiary access. Furthermore, CMS continues to be interested in developing new or enhanced measures of beneficiary access, especially with the industry-wide collection of data from sponsoring organizations as described earlier.

*Centene supports the addition of measurement concepts for use of non-pharmacological or non-opioid pain management interventions. To effectively reverse the opioid epidemic, Medicare and Medicaid will need to fund and evaluate the effectiveness of new and alternative modalities of pain control.*

*Centene also supports CMS retaining measures that are "topped out" in the Stars program if they are important to patient outcomes and safety or if they meet another key focus of the star ratings. We would suggest that increases in rates may correlate with inclusion in the Star Rating program and that removal of certain measures may result in less attention than if it were part of the Star Ratings.*

*Finally, in order to ensure that CAHPS performance outcomes provide an accurate reflection of member satisfaction within the corresponding rating year, we encourage CMS to consider fielding the survey during the Fall of the measurement year instead of the following Spring. By moving up the continuous enrollment criteria to 1/1 of the measurement year instead of 7/1, CMS could continue to ensure that the beneficiary had adequate exposure to plan operations while providing a more accurate assessment of health plan services and operational efficiencies reflected in a plan's Star Ratings.*

## Validation Audits (Page 159)

CMS is considering several process improvements and enhancements to the program audit validation process that are intended to promote consistency and decrease burden on plan sponsors.

- CMS currently requires sponsoring organizations that have more than five program audit conditions in their final audit report to hire an independent auditing firm to conduct a validation audit. CMS conducts the validation audits of sponsoring organizations that fall below this threshold. CMS is seeking comments on whether this threshold should be increased or decreased or limited to conditions that may cause adverse impacts to beneficiaries.

*Centene supports changing the current protocol and limiting the independent validation audit to conditions that may cause adverse impacts to beneficiaries. CMS already reviews CAPs for all conditions and reserves the right to conduct reviews prior to approving CAPs. This process should suffice for conditions that are determined to not cause adverse impacts to beneficiaries as it provides a good balance between CMS' need to ensure CAPs are effectuated versus the burden to the plan in conducting the IVA.*

- CMS wants to clarify that sponsoring organizations are not precluded from selecting the same independent auditing firm that is used for their annual external CPE audit, as long as the firm has not provided consulting services or assistance with the correction of audit findings.

*Plans are already required to perform this function. It might make more sense for CMS to spot check plans to ensure they are performing the conflict of interest assessment appropriately. Also, by the time CMS has begun collecting information from the IVAs in the validation work plan, the Sponsor has already spent considerable time and resources vetting potential IVAs. It would be more helpful for CMS to provide clearer guidance regarding what they consider to be a potential conflict of interest and afford the Sponsor the opportunity to work with their assigned CMS audit lead to discuss any concerns.*

*Furthermore, Centene asks that CMS limit the requirement to utilize an independent audit firm for those plans that hit the threshold of 5 or more conditions that may cause adverse impacts to beneficiaries. By focusing on this area, CMS will be able to impact those issues that are causing the most harm or potential harm to beneficiaries.*

- CMS intends to create a validation work plan template that sponsoring organizations undergoing independent validation audits in 2019 would be required to submit. CMS believes that a CMS specified standardized work plan template will facilitate consistency across all validation audits and may also help to standardize the cost of an independent audit and improve inter-rater reliability across independent auditors.

*Centene supports the proposed changes and agrees with CMS' stated reason for implementing the change.*

## Timeframe to Complete Validation Audits (Page 163)

CMS agrees with the commenters and intends to extend the timeframe by 30 days—thus, sponsoring organizations would have 180 days from the date that CMS accepts their program audit CAPs to undergo a validation audit and submit the independent audit report to CMS for review.

*Centene supports the proposed changes and agrees with CMS' stated reason for implementing the change.*

#### Plan Finder Civil Money Penalty (CMP) Icon or Other Type of Notice (Page 164)

In an effort to remain transparent with enrollees when sponsoring organizations receive a CMP for violations of program requirements, starting with the 2019 Annual Election Period (AEP), CMS intends to display an icon or other type of notice on Plan Finder for sponsoring organizations that have received a CMP.

*Centene agrees with providing beneficiaries with access to relevant CMP information to aid in plan selection, but believe this proposal as written would not accomplish this goal. For example, low dollar CMPs should be exempt and Centene recommends CMS set thresholds for when the CMP icon would be displayed. Since CMPs are typically issued when there is potential adverse impact to beneficiaries, one suggestion is to set the threshold based on a percentage of enrolled members adversely impacted. Setting the threshold using this method would normalize for low versus high volume plans. Another option is to set the threshold based on dollar amount; however, this would work better if CMS were to establish staggered thresholds depending on enrollment size. We look forward to reviewing additional details on this proposal and suggest additional ways this policy could best provide beneficiaries useful and timely plan information.*

#### Audit of the Sponsoring Organization's Compliance Program Effectiveness (Page 165)

Sponsoring organizations are required annually to audit the effectiveness of their compliance program and share results with their governing body. CMS is considering allowing sponsoring organizations that have undergone a program audit to treat the program audit as meeting the annual compliance program audit requirement for one year from the date of the CMS program audit.

*CMS would recommend that CMS take this one step further and consider allowing the plans to perform their compliance program effectiveness audit one year after the Program audit has been closed. This would allow the Sponsor to ensure remediation of all corrective actions prior to another audit taking place.*

### **ATTACHMENT VI. DRAFT CY 2019 CALL LETTER (SECTION II – PART C)**

#### Outpatient Observation Services (Page 182)

In an effort to make the cost sharing for observation services more transparent, CMS will distinguish the cost sharing for observation services from other outpatient hospital services by modifying PBP category B9a to include separate cost sharing data entries.

*Centene supports the proposed changes and agrees with CMS' stated reason for implementing the change as this provides more clarity of cost sharing for observation services.*

#### Health Related Supplemental Benefits (Page 182)

CMS has not previously allowed an item or service to be eligible as a supplemental benefit if the primary purpose is daily maintenance. CMS intends to expand the scope of the primarily health related supplemental benefit standard.

*Centene fully supports CMS' proposal to expand the scope of the supplemental benefit standard for all beneficiaries to include services or items that, among other things, "reduce avoidable emergency and healthcare utilization." Centene*

*looks forward to receiving detailed sub-regulatory guidance from CMS on this issue, particularly as it relates to personal care and social determinants of health (such as employment supports, housing, transportation, etc.), as we, and others looking at this issue, understand the magnitude that social determinants of health can have on overall health outcomes. The ability to address these determinants in a targeted way (i.e. combined with flexibility on the uniformity requirement) provides managed care organizations a very powerful tool to truly impact the trend in health costs while simultaneously delivering meaningful improvements in outcomes.*

*We also note that the Bipartisan Budget Act of 2018 (BBA) includes a provision that allows for expanded supplemental benefits for individuals with chronic illnesses beginning in 2020. We believe that the BBA provision should be viewed as being complementary to CMS's preexisting interpretive authority about the scope of permissible supplemental benefits. That is, the BBA provision now ensures that MA plans must be permitted to offer expanded supplemental benefits to chronically ill beneficiaries beginning in 2020. However, the provision also indicates it applies "in addition to any supplemental health care benefits otherwise provided under this paragraph". We believe this allows CMS to exercise its interpretive authority to expand supplemental benefits beyond those in the BBA provision, including making them available in 2019. We therefore urge CMS to finalize its proposal to apply its new interpretation for 2019, so Medicare beneficiaries may have the ability to access a wider array of items and services to meet their individual needs. We also support CMS' intention to offer detailed guidance in advance of bid submissions.*

#### **Enhanced Disease Management (EDM) for Dual Eligible Special Needs Plans (D-SNPs) and Institutional Special Needs Plans (I-SNPs) (Page 183)**

Beginning with CY 2019, D-SNPs and I-SNPs may offer the EDM supplemental benefit that is currently available to Non-SNP MA plans.

*Centene supports the proposed changes and agrees with CMS' stated reason for implementing the change as this allows us more flexibility in offering supplemental benefits.*

#### **Medicare Advantage (MA) Uniformity Flexibility (Page 184)**

CMS reiterates its position to change its interpretation of the uniformity requirements as previously discussed in this fall's proposed regulations. CMS emphasizes the need to continue to comply with non-discrimination requirements.

*Centene appreciates and strongly supports the flexibility that CMS is proposing to provide plans an option to tailor benefits to best meet the needs of the beneficiaries we serve. CMS references "medical criteria" when discussing tailoring benefits, but certain kinds of benefits, such as those that address social determinants of health, are likely to be most impactful on lower income individuals, in particular for those that are dually eligible for Medicaid and Medicare. Benefits that address social determinants of health may include food and housing insecurity along with those benefits that are considered "in lieu of services." For example, a low-income individual that is frequently visiting the emergency department in warmer months may benefit from the provision of an air conditioner that may prevent avoidable emergency department visits. These benefits may be best suited for individuals that are diagnosed with a chronic condition and are low-income rather than one or the other. While Centene is supportive of allowing for more flexibility in the uniformity requirements, we advocate that income be an allowable criterion for tailoring benefits. We recommend this be operationalized by using the low-income subsidy (LIS) identifier that's a part of Part D to serve as an indicator for allowing plans to tailor benefits based on income.*



*In addition, this proposal has been limited to the Part C program and we would advocate that CMS extend this flexibility to the Part D program as well. There are significant advantages to tailoring drug benefits for individuals so that the drugs that help manage their chronic condition are more accessible and affordable.*

### Medicare Diabetes Prevention Program (MDPP) Services Clarification (Page 185)

CMS wants to ensure that MA plans are aware that while they must cover MDPP services in accordance with the MDPP regulations, they may also offer additional MDPP-like services as a supplemental benefit.

*Centene supports the proposed changes and agrees with CMS' stated reason for implementing the change as this allows plans the option to offer additional MDPP services.*

### Special Needs Plan (SNP)-Specific Networks Research and Development (Page 185)

CMS believes that the current network adequacy criteria and exception request process accounts for the unique healthcare needs and delivery patterns for Medicare Advantage (MA) beneficiaries enrolled in SNPs, including chronic condition SNPs (C- SNPs), dual eligible SNPs (D-SNPs), and institutional SNPs (I-SNPs). It continues to examine the need for SNP-specific network adequacy evaluations and welcomes continued stakeholder feedback.

*Centene does not believe the current network adequacy criteria and exception process accounts for the unique healthcare needs and delivery patterns for MA enrollees in SNPs, MMPs, and other integrated plans (particularly in rural areas), and strongly encourages CMS to move forward on developing SNP-specific network adequacy evaluations. One example where this could greatly help is in rural areas. Today, the pool of integrated plans that compete to serve rural areas is limited partially because of the burdensome regulatory process required to meet Medicare Network Adequacy criteria ((42 CFR 422.112(a)). Plans that cannot meet Medicare Network Adequacy criteria in rural areas must request an exception, demonstrate that the pattern of care in that area is exceptionally unique, and show that the organization's contracted network is consistent with or better than the original Medicare pattern of care. To prove the pattern of care rationale, MCOs must provide internal claims data evidence and a detailed explanation that demonstrate the current pattern of care for enrollees in the given county for the given specialty type. It is an extremely lengthy and challenging process that presents a significant barrier to MCOs wishing to enter and serve rural markets. Centene recommends CMS reduce the regulatory burden of this process and give States and MCOs more flexibility around the rural network adequacy requirements so that they may account for things such as telehealth.*

### Rewards and Incentives for Completion of a Health Risk Assessment (HRA) (Page 186)

CMS recognizes that HRA tools must be designed to objectively assess and analyze the medical, functional, cognitive, psychosocial, and mental health needs of each beneficiary, and therefore do not consist of material that is susceptible to bias like other enrollee satisfaction and outcome surveys. Therefore, beginning CY 2019, MA plans may include the completion of an HRA as a permitted health-related activity in an RI (Rewards and Incentives) Program. An RI Program is not a benefit, but it must be included in the bid as a non-benefit expense.

*Centene fully supports CMS' decision to allow the completion of an HRA as a permitted health-related activity in a Rewards and Incentives (RI) Program and predicts this will have a significant impact on the overall percentage of HRAs completed and returned. There is a widespread misperception among the public that providing health information to a*

*health plan will result in the denial of care; this decision will greatly help overcome that misperception and get the data plans need to provide quality care for our members.*

#### **Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs (Page 187)**

CMS has identified the following specific areas in which administrative alignment for integrated D-SNPs is currently feasible within existing statutory, regulatory, and operational constraints: oversight, integrated model materials (including summary of benefits, Annual Notice of Change/Evidence of Coverage, Provider and Pharmacy Directory, and Formulary), D-SNP Non-Renewals, and Model of Care.

*Centene supports all of the opportunities outlined in the draft Call Letter to promote administrative alignment that will benefit dually eligible beneficiaries, including more robust D-SNP model of care (MOC) submissions that incorporate information about the integration of Medicare and Medicaid ABD/LTSS. Additionally, Centene asks CMS to better align for composition/identification of the Medicaid benefits in the PBP for MMPs. For example, the model benefit in the EOC may be listed as “Day Habilitation Services” but in the PBP it is listed under 13H Other 7 “Adult Day Health Services & Nursing Services”.*

*Generally, one of the best things CMS can do to promote administrative alignment for duals, however, is to make the Financial Alignment Initiative (FAI) a permanent program within MMCO at the end of the demonstration period, and extend by two years the current demonstration period for any States with capitated models for Medicare-Medicaid beneficiaries through the FAI that wish to extend. In addition to the areas of administrative alignment noted in the Call Letter, Centene recommends, among other things, that CMS extend the current FAI demonstrations, expand the three-way contracts allowed under FAI to new states, and examine how the DSNPs and MMPs align when operating in the same market.*

#### **MACRA Medicare Advantage APM Demonstration.**

*CMS indicated in the MACRA CY 2018 final rule that the agency intends to develop a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative APMs under Medicare Advantage that qualify as Advanced APMs. We urge CMS to work with health plans and other stakeholders to design and implement the demonstration.*

#### **ATTACHMENT VI. DRAFT CY 2019 CALL LETTER (SECTION III – PART D)**

##### **CY19 Formulary Reference File (FRF) (Page 193)**

CMS intends to update the FRF to no longer include drugs that are commonly not used or may cause consumer confusion. Additionally, CMS intends to move the formulary update window later into the summer with the goal being that more newly approved brands and generics can be included.

*Centene supports the removal of drugs that are not commonly used or cause confusion from the FRF. However, we would not be supportive of moving the formulary update window into later in the summer due to timeframes for producing materials for AEP unless those timeframes will also be moved.*

## Changes to the CY19 Formulary Submissions (Page 195)

CMS intends to make changes to the Additional Demonstration Drug (ADD) file, Non-Extended Day Supply (NDS) File, and Over-the-Counter (OTC) Validation File.

*Centene supports the proposed changes and agree with CMS' stated reason for implementing the change as adding the ADD file to HPMS will make it easier to track.*

## Improving Drug Utilization Review Controls in Medicare Part D (Page 202)

*Centene supports the addition of strategies aimed at more effectively addressing overdose and abuse of prescription opioids but understand this needs to be implemented while simultaneously providing access to necessary pain relief. Many Medicare and Medicaid LTSS beneficiaries with disabilities experience ongoing, chronic pain. While access to new and alternative of modalities of pain control is essential, for some beneficiaries with certain disabilities alternatives are not effective, and access to opioid therapy is a critically needed option that should be available without unnecessary hoops or stigma for practitioners or patients. We would appreciate any opportunity to engage in ongoing discussion on this important topic in order to spread Medicaid best practices into Medicare and create greater alignment for dual eligible beneficiaries.*

## Retrospective DUR (Page 204)

### **OMS Metrics**

Beginning in April 2018, CMS will report:

- 90 MME Opioid Daily Dose rate: # opioid days > 90 MME/1000 Opioid utilization days during the last 6 months.
- 120 MME Opioid Daily Dose rate: # opioid days > 120 MME/1000 Opioid utilization days during the last 6 months. This metric will be discontinued in the 2019 OMS reports.

*Centene supports these changes as they align more closely to CDC recommendations.*

### **Opioid Potentiator Drugs**

CMS is looking to identify non-opioid potentiators to flag, similar to how benzodiazepines are handled in OMS. Thus far, they are considering flagging gabapentin/pregabalin, but are looking for feedback on other potential drugs that should be included.

*Centene would recommend limiting flags to benzodiazepines until further results have been seen with their addition. We believe this narrow approach keeps focus on only those potentiators with serious potential for adverse effects.*

## Concurrent DUR (Page 207)

### **Cumulative Morphine Milligram Equivalent Daily Dose (MME) Safety Edits for High, Chronic Prescription Opioid Users and Days Supply Limits for Opioid Naïve Patients**

CMS proposes that all sponsors should implement a hard edit in 2019 that is triggered when a beneficiary's cumulative daily MME reaches or exceeds 90 mg (meaning the MME threshold should be set at 90 MME).

CMS also expects Part D sponsors to implement a hard safety edit for initial opioid prescription fills that exceed 7 days for treatment of acute pain—they ask for feedback on this approach, in particular if an alternative day supply limit would be more appropriate (e.g., 3 or 5 days).

*Centene supports the concept of these changes. It will allow Medicare to be more consistent with efforts in curbing opioid overutilization for other lines of business at Centene. Nonetheless, we anticipate these changes will have impact on pharmacies as new prescriptions could be required if only partial fills are allowed and may cause CTMs, higher call volume, prior authorization requests, etc. To this end, having consistency across the MA program on implementation will reduce beneficiary, prescriber, and pharmacy confusion. To the extent that there can be alignment it will also reduce downstream differences in complaints, appeals, member satisfaction and provider relations that could result from inconsistent adoption. Additionally, we seek further clarification on whether authorization requests shorter than 7 days will need to be treated as expedited.*

### **Opioid Duplicative Therapy Safety Edit**

CMS expects all Part D plan sponsors to implement a soft POS edit for duplicative long-acting opioid therapies beginning in 2019, with or without a multiple prescriber criterion.

*Centene supports implementation of the soft edit for duplicative long-acting opioid therapies and placement of at least one MAT treatment in a preferred status. We also support requirement for PA to be approved when appropriate until end of plan year. However, Centene does not support specific call out of MAT generic medications only being allowed in generic tiers and does not support any recommendation that prevents all PA for MAT given the possibility of abuse with these medications.*

## **ATTACHMENT VI. DRAFT CY 2019 CALL LETTER (SECTION IV - MEDICARE-MEDICAID PLANS)**

*Section IV of the Call Letter states that in addition to the requirements for MA and Part D plans, MMPs must also submit network adequacy information on an annual basis and have States evaluate their networks for Medicaid service providers, including long-term services and supports (LTSS). Centene recommends CMS and States ensure alignment and coordination of the LTSS network adequacy evaluation with the LTSS network adequacy standards required in the 2016 Medicaid and CHIP Final Rule (CMS-2390-F). While States should have the opportunity to innovate, a set of national LTSS network adequacy standards would allow for consistency across States, the ability to compare/benchmark, and reduce administrative expenses. To begin to address this, Centene recommends CMS issue a national set of home-and-community-based services (HCBS) network adequacy standards based on three measures: 1. Time to placement; 2. Missed appointments; and 3. Late visits.*

**1. Time to Placement:** *“Time to placement” refers to how long it takes from the time a given service is requested by the payer (based on the completion of the beneficiary’s person-centered care/service plan) to the time the beneficiary receives the service at the beneficiary’s location, which is commonly referred to as the “beneficiary’s placement.” The longer the time to placement, the weaker the LTSS network adequacy. Prompt access to high quality LTSS services can sometimes mean the difference between life and death or hospitalization for an LTSS*

*beneficiary. The fact that a given provider is physically located near a beneficiary is of no significance if the provider, for whatever reason, is unable to promptly provide service to the beneficiary at the beneficiary's location.*

**2. Missed Visits/Appointments:** *A second measure of network adequacy for LTSS services provided at the beneficiary's location is the number of scheduled visits or appointments that do not occur (excluding those cancelled by the member). If an LTSS beneficiary's personal attendant does not show up in the morning, for example, that beneficiary literally cannot perform essential functions needed to live, such as getting out of bed, eating, or going to work. The higher the number of missed visits there are, the weaker the LTSS network adequacy would be.*

**3. Late Visits/Appointments:** *Similarly, the higher the number of late visits there are, the weaker the LTSS network adequacy would be. This measure could be based on a count of the number of scheduled visits/appointments that start more than 30 minutes after the scheduled time (or another agreed-upon time depending on the service), again excluding those changed by the member.*

*Centene also supports LTSS network adequacy standards that acknowledge and account for differences between urban and rural areas, as well as agency-directed and self-directed personal attendant services. States should solicit feedback from beneficiaries of self-directed attendant services to assist in assessing network adequacy.*

Thank you for the opportunity to comment. If you have questions or need more information, please contact me at [jdinesman@centene.com](mailto:jdinesman@centene.com) or 314.505.6739.

Sincerely,

A handwritten signature in blue ink, appearing to read 'JDinesman', with a stylized flourish at the end.

Jonathan Dinesman  
Senior Vice President, Government Relations  
Centene Corporation