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Submitted via Federal e-Rulemaking Portal: <http://www.regulations.gov>

January 16, 2018

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

**Re: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program**

Dear Administrator Verma:

Anthem, Inc. ("Anthem") appreciates the opportunity to provide comments in response to the Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program proposed rule, released on November 16, 2017.

Anthem shares CMS' commitment to continuously identifying and implementing innovative approaches for providing Medicare benefits to enrollees, and empowering beneficiaries to make the best health care decisions for their unique needs. As a committed participant in the MA and Part D programs, we believe the best way to carry through on this commitment is to emphasize transparency, flexibility, and efficiency, including finding ways to simplify rules. To that end, Anthem commends CMS for proposing numerous policy changes to the MA and Part D programs that all aim to increase choices, lower premiums, and simplify regulations.

In particular, we support CMS' proposals to provide significant new flexibility for Medicare Advantage Organizations (MAOs), including new flexibility in benefit uniformity, elimination of the meaningful difference requirement, changes in the Part D transition policy, and elimination of burdensome provider and prescriber enrollment requirements that have raised serious beneficiary access and administrative burden issues. These new flexibilities—in combination with elimination of burdensome rules—will allow plans to continue providing high-quality care to beneficiaries with greater efficiency. Anthem encourages CMS to finalize many of these provisions as proposed.

Anthem also appreciates many of the steps CMS is proposing to take to promote movement toward a more integrated and seamless system of care for all individuals, especially those who have dual eligibility for Medicare and Medicaid. To ensure these efforts are successful as possible, we recommend that CMS finalize with modifications its proposals regarding default enrollment, passive enrollment, and the limitations on the Part D Special Election Period (SEP) for dual eligibles. By strengthening these proposals per the recommendations described in detail below, CMS will support initiatives that aim to improve outcomes and reduce costs for a highly vulnerable patient population.

Finally, Anthem understands the issues CMS is attempting to address in its consideration of policy approaches for applying some manufacturer rebates and all pharmacy price concessions to the price of a drug at the Point of Sale (POS). We agree that steps must be taken to curb the rising costs of prescription drugs and the long-term viability of the Part D program, including the subsequent impact on beneficiaries. However, we strongly recommend that CMS not move forward to implement POS rebates, as the options detailed in the proposed rule do not address the fundamental problem and, more importantly, would lead to significant negative implications for consumers.

Anthem thanks CMS for the opportunity to provide the following detailed comments and recommendations:

### **Anthem's Detailed Comments on the Provisions of the Proposed Regulations**

#### **Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions**

##### **Establishment of Part D Drug Management Program—Definitions (§423.100)**

*Issue:* For plan year 2019, CMS proposes to only designate opioids as frequently abused drugs, except for buprenorphine when used as a medication-assisted treatment. This supersedes current policy of identifying non-opioid drugs for Drug Utilization Review (DUR) and Overutilization Monitoring System (OMS) efforts.

*Recommendation Summary:* To enhance beneficiary safety and effective implementation of the drug management program, CMS should expand the frequently abused drugs definition to include other highly abused drugs, such as sedative-hypnotics and drugs commonly used in combination (i.e., triple threat, which may include opioids, benzodiazepines and muscle relaxers).

Anthem also asks CMS to clarify that methadone will be considered a frequently abused drug under the proposed drug management program.

*Recommendation Detail:* Including only opioids in the definition of frequently abused drugs may have the unintended consequence of steering potentially at-risk or at-risk individuals towards use of other highly abused drugs. Anthem encourages CMS to consider adding sedative-hypnotics, particularly benzodiazepines, to the definition of frequently abused drugs. Given that more than 30 percent of overdoses involving opioids also involve benzodiazepines, a sedative-hypnotic, expanding the frequently abused drug definition in this manner will ensure that the Part D drug management program is truly focused on those individuals at highest risk for drug-related emergencies.<sup>1</sup>

Anthem notes that while methadone is not a Part D drug when used for treatment of opioid dependence, it is a Part D drug when indicated for pain, and is therefore included in Part D sponsors' retrospective DUR programs. However, the proposed rule is unclear as to whether methadone would be considered a frequently abused drug under the drug management program. Given methadone's treatment as a Part D drug when used for pain—and to ensure alignment with current retrospective DUR standards—Anthem asks CMS to clarify that methadone would be included in the definition of a frequently abused drug.

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<sup>1</sup> <https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids>

## Requirements of Drug Management Programs [§§423.153, 423.153(f)]

*Issue:* In the proposed rule, CMS outlines a number of requirements that plans must meet in order to implement a drug management program, including requirements around written policies and procedures, case management, clinical contact, and prescriber verification.

*Recommendation Summary:* When implementing drug management program requirements under CARA, CMS should consider how federal regulations and guidance for drug management programs at the national level will interact with state-level Prescription Drug Monitoring Programs (PDMPs).

*Recommendation Detail:* Substance use disorders are chronic conditions which require an integrated and holistic plan to support each individual and that individual's family. In recognizing the priority that should be placed on addressing the escalating opioid epidemic, and the important role of the health plan in the collective effort, Anthem has instituted a comprehensive suite of services designed to meet the growing need. Such services range from medication assisted treatment, to peer recovery supports, community treatment options, and chronic pain management. At the core of our strategy are the fundamental objectives of prevention, treatment, recovery, and deterrence. As part of our strategy, Anthem reached the company's collective goal of reducing prescribed opioids filled at pharmacies by 30 percent since 2012—two years earlier than the initial goal. Anthem has now updated its goal to achieve a 35 percent reduction by 2019. We commend CMS for its ongoing dedication to address the opioid epidemic, and thank the Agency for the efforts it has undertaken to propose a framework for the Part D drug management program established under CARA. Anthem agrees that incorporation of the CARA drug management provisions into existing CMS and sponsor operations will make significant strides in addressing the opioid epidemic.

Today, 49 states and the District of Columbia have authorized and operationalized PDMPs<sup>2</sup> to collect data from pharmacies on the prescribing of controlled substances, review and analyze the data, and report them to prescribers. The data is also used to facilitate referrals to substance use treatment and inform prevention strategies by providing population-level data on opioid use.<sup>3</sup> While these goals are generally aligned across states, the specific characteristics of each state's PDMP differ—for instance, states vary in the types of drugs with abuse potential that they monitor, as well as in how frequently data must be updated.

States and the federal government have their own important perspectives on addressing the country's opioid epidemic. Anthem urges CMS to ensure that implementation of CARA's Part D drug management programs takes into account state PDMPs, to the extent possible, so that rules and requirements are clear and goals are aligned. It will be important for sponsors, states, beneficiaries, prescribers, beneficiary advocacy groups, and any other relevant stakeholders to understand how the Part D program and PDMPs interact/coordinate, and whether the federal Part D requirements augment a sponsor or provider's responsibility to adhere to state-level PDMPs.

Further, health plans should be granted access to PDMPs. Increased information, with appropriate privacy protections, supports the provision of holistic and integrated care. PDMP access for plan sponsor drug management programs would provide useful insight into data that is broader than line of business or benefit specific. Additionally, health plans do not receive information on prescriptions paid in cash or by other third party payers, while PDMPs do collect this data. Since PDMPs collect information on filled prescriptions from all dispensers in a state, including those paid for in cash, PDMP data can provide a more complete picture of which controlled substances an individual may be using or diverting, and those

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<sup>2</sup> <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>

<sup>3</sup> <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.1496>

substances being prescribed. With a clear and complete view of the data, plan sponsors can serve as the best advocate for the member and be best suited to provide coordinated care and resources. Currently, access to PDMP data is granted to a plan sponsor's pharmacist or other designated licensed professional, by state.

Finally, we note that the CARA legislation requires the Secretary to provide education to Prescription Drug Plan (PDP) enrollees and providers regarding the drug management program for at-risk beneficiaries through Medicare administrative contractors' improper payment outreach and education program and state health insurance assistance programs. Since the proposed rule is silent on this requirement, Anthem asks CMS to confirm its role in this education, and to provide more information regarding how this information will be distributed to the specified channels.

Addressing the national opioid epidemic necessitates coordination across a multitude of entities. Anthem again thanks CMS for its leadership in this arena and, as efforts continue, urges the Agency to set clear expectations and facilitate robust communication across stakeholders to ensure the success of initiatives aimed at curbing opioid overutilization.

#### Chain Pharmacies & Group Practices [§§423.100 and 423.153(f)(12)]

*Issue:* As per current policy, CMS proposes that prescribers with a shared Tax Identification Number (TIN) are to be considered as only one prescriber to avoid over-identifying at-risk beneficiaries. In addition, if a pharmacy has multiple locations that share real-time electronic data, then all locations should be treated as a single pharmacy. Therefore, if a sponsor were to choose a chain pharmacy or group practice for its pharmacy home (lock-in) program, a beneficiary will have access to all prescribers within that group and all pharmacy locations within that chain as part of the pharmacy home program.

*Recommendation Summary:* Anthem supports CMS' proposal as it relates to group practices and chain pharmacies, but notes that managing this option will be challenging absent additional instructions from CMS.

*Recommendation Detail:* While allowing all prescribers within a group and all pharmacies within a chain to be part of the pharmacy home program is a characteristic of the drug management program that Anthem supports, we caution that sponsors do not have an effective way to manage such arrangements. We note that Maryland's Medicaid program currently permits a similar construct, but the State experiences significant struggles with maintaining it due to constant changes at the provider level. In order to ensure successful implementation and maintenance of this program component, Anthem urges CMS to develop a better identifier for knowing who is assigned to which provider group. Anthem would be willing to participate in additional workgroups, comment processes, or other stakeholder engagement opportunities to assist in developing the most appropriate framework.

#### Beneficiaries Exempted from the Part D Drug Management Program (§423.100)

*Issue:* CMS would exempt from the drug management program Part D enrollees who receive hospice care, are residents in a Long-term Care (LTC) facility, or have a cancer diagnosis.

*Recommendation Summary:* CMS should consider further tailoring the exemptions list to be more specific about when cancer patients should be excluded from the drug management program. Anthem also asks CMS to clarify whether LTC facilities would be exempt from retrospective DUR under this policy.

*Recommendation Detail:* Anthem understands that CMS believes Part D drug management programs should not be able to interfere administratively with a beneficiary's pain control regimen in the form of

additional notices and limitations on their access to coverage for frequently abused drugs. We also agree that beneficiaries with cancer should often be excluded from drug management programs because the benefit of their opioid use may outweigh the risk associated with their opioid use. However, Anthem is concerned that CMS' proposed exemption for a "cancer diagnosis" is too broad. A more appropriate approach would be to exempt beneficiaries with a current cancer diagnosis, or who are currently being treated for a cancer diagnosis. Without more specific parameters, beneficiaries who no longer have an active cancer diagnosis but are at-risk for misusing frequently abused drugs could be inappropriately overlooked by drug management programs.

In addition, Anthem seeks clarity about the treatment of beneficiaries residing in LTC facilities—while CARA requires these individuals to be excluded from drug management programs, it is unclear if they would also be exempt from retrospective DUR programs. Although these individuals are already likely to be limited to one provider and one pharmacy within a LTC facility, Anthem asserts that they would still benefit from case management. We request additional insight from CMS on this issue.

#### Limitations on Access to Coverage for Frequently Abused Drugs [§423.153(f)(3)]

*Issue:* In order for a plan sponsor to place a beneficiary in a drug management program, CMS proposes that the plan sponsor must first obtain the agreement of the health care professional who prescribed the frequently abused drug to the beneficiary.

*Recommendation Summary:* Anthem asks CMS to provide additional details about what options plans would have if a prescriber does not agree to a pharmacy home program. In addition, CMS should clarify how the prescriber agreement would have to be documented and shared with the appropriate parties.

*Recommendation Detail:* Anthem has concerns about the requirement to obtain prescriber agreement, as some prescribers may be unwilling to agree to a pharmacy home program. Although prescribers may agree to a pharmacy home as part of contracting terms, obtaining prescriber agreement on a case-by-case basis may be challenging depending on the patient. If prescribers refuse to agree to these agreements, this may limit members' access to the medications. Anthem believes that a better approach would be for individuals to identify a primary prescriber, as this would help drug management and increase beneficiary safety. In the DUR program, primary decision makers are identified as part of the case management process, which has proven to be an effective approach to ensure beneficiary safety.

#### Limitations on Access to Coverage of Frequently Abused Drugs to Selected Pharmacies and Prescribers [§§423.153(f)(4) and (f)(9) through (13)]

*Issue:* CMS proposes that a sponsor may not limit an at-risk beneficiary's access to coverage of frequently abused drugs to a selected prescriber(s) until at least six months have passed from the date the beneficiary is first identified as a potential at-risk beneficiary.

*Recommendation Summary:* CMS should not impose a waiting period for plan sponsors to implement a prescriber home program for at-risk beneficiaries, nor should CMS require sponsors to apply drug management tools in a hierarchy.

*Recommendation Detail:* Based on historical claim review and OMS criteria—which contains six months of claims data to review to define a member's at-risk behavior—plans can quickly determine whether a beneficiary is at-risk and should be placed in a drug management program under the necessary management techniques. Requiring sponsors to wait an additional six months prior to implementing a prescriber home could undermine the efficacy of the drug management program, as it would prevent sponsors from acting quickly in the best interests of the at-risk beneficiary. Furthermore, although CMS

states that a prescriber home should be a “tool of last resort,” Anthem asserts that POS claim edits, pharmacy home programs, and prescriber home programs should be viewed as three equal mechanisms for limiting beneficiaries’ access to frequently abused drugs, and not in a hierarchical manner. Because the effectiveness of each technique may differ depending on each beneficiary’s circumstances, plans should have sufficient latitude in deciding which tool to use for which beneficiary and when.

#### Special Enrollment Period for LIS Beneficiaries with an At-Risk Status (§423.38)

*Issue:* CMS proposes that dual and Low-Income Subsidy (LIS)-eligible beneficiaries qualifying for the drug management program are unable to use the SEP for LIS beneficiaries due to their at-risk status.

*Recommendation Summary:* Anthem supports CMS’ proposal to limit the SEP for subsidy-eligible at-risk beneficiaries.

*Recommendation Detail:* CMS’ proposed SEP limitation would be an important tool to reduce the opportunities for LIS-eligible beneficiaries designated as at-risk to switch plans and ultimately avoid the drug management program. Anthem agrees that limiting the SEP in this manner will help ensure that especially vulnerable at-risk beneficiaries receive needed care coordination to manage their potential or actual overutilization of frequently abused drugs.

#### Termination of a Beneficiary’s Potential At-Risk or At-Risk Status [§423.153(f)(14)]

*Issue:* CMS proposes that a beneficiary’s at-risk status would be terminated at the earlier of the following: a subsequent determination that the beneficiary is no longer likely to be an at-risk beneficiary, or 12 months after the effective date of the at-risk limitation.

*Recommendation Summary:* A beneficiary’s at-risk status should not be terminated 12 months after the effective date of the at-risk limitation. Instead, Anthem recommends that plan sponsors should be permitted to conduct a review of the beneficiary’s pharmacy/prescriber home and at-risk status at 12 months with a termination after 24 months.

*Recommendation Detail:* Automatic termination of a beneficiary’s at-risk status after 12 months threatens beneficiary safety and imposes undue administrative burden on plans, particularly because at-risk beneficiaries will be potentially at-risk for inappropriate use or overutilization for their lifetimes, given the nature of substance use disorders. In Anthem’s Pharmacy Home Program—which helps high-risk members in individual and employer-sponsored plans reduce addiction to opioids and other prescription drugs, and improve drug safety and health care quality by choosing one home pharmacy to fill their prescriptions—a member’s activity is reviewed at 12 months to determine whether management techniques should be continued or if the member is no longer at risk and can be removed from the program. We recommend that CMS implement a similar approach for the Part D drug management program: sponsors should be required to review a beneficiary’s participation in the drug management program at 12 months, with a termination occurring 24 months after the effective date of the at-risk limitation. This would be a more appropriate way to ensure beneficiary safety and we urge CMS to implement this modification to the proposal.

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

#### Flexibility in the Medicare Advantage Uniformity Requirements (pg. 56360)

*Issue:* Beginning with Calendar Year (CY) 2019, CMS proposes to allow MA plans the flexibility to offer targeted supplemental Part C benefits to medically vulnerable enrollees. These benefit packages could

offer differential access to enhanced services, or reduced cost-sharing or different deductibles for certain services, and MA plans must use objective and measurable criteria to identify enrollees eligible for such tailored supplemental benefits.

*Recommendation Summary:* Anthem appreciates the additional flexibility that CMS is proposing for MA plans to tailor benefits to their members, which should include sufficient latitude for plans to identify eligible enrollees. We also urge CMS to clarify that plans will have the ability to appropriately market these benefits to eligible members—and that the Agency will undertake beneficiary education efforts—to mitigate confusion and ensure that beneficiaries are able to make informed coverage decisions that best meet their health care needs.

*Recommendation Detail:* Anthem is focused on ensuring the provision of high-quality, innovative MA plans that improve care delivery, promote wellness and management of vulnerable populations, and achieve meaningful cost-savings for our members and the overall Medicare program. CMS' proposal would allow MA plans to further these goals by removing remaining barriers to designing benefits that are tailored to be medically related to a member's condition. This flexibility would also help generate patient engagement, leading to higher levels of compliance with evidence-based medicine standards. Anthem commends CMS for proposing to allow this additional flexibility. It is an important step to ensure that medically vulnerable beneficiaries are receiving the best care for their needs, while also reducing the use of unnecessary, duplicative care.

As CMS looks to promote patient-centered care, Anthem recommends that plans have sufficient flexibility to determine the “objective and measurable” criteria it will use to identify individuals eligible for tailored supplemental benefits. Plans should be able to base eligibility on more than just diagnosis of disease; for example, plans may determine that tailored benefits may be most appropriate not just for beneficiaries with diabetes, but diabetes beneficiaries with hemoglobin A1c levels of 10 percent or greater. Similarly, plans should have the ability to set criteria inclusive of Social Determinants of Health (SDoH), given the critical role these factors play in an individual's physical and mental health. Appropriately understanding and accounting for the impact of SDoH as part of this proposed flexibility will enable plans to better serve members holistically and improve health outcomes and cost effectiveness over time. An individual with diabetes may be less likely to adhere to a treatment plan if he or she is economically unstable, or lacks housing, transportation, food, or social supports. Thus, plans should be able to determine that beneficiaries with a particular diagnosis (e.g., diabetes) and certain SDoH are eligible for tailored benefits. As the health care system becomes increasingly patient-centric, plans should be positioned to use CMS' proposed additional flexibility in ways that are most beneficial to patients.

We note that there are similarities between the kind of flexibility CMS is contemplating granting general MA plans, the tailored offerings of Chronic Condition Special Needs Plans (C-SNPs), and the initiatives being tested under the MA Value-Based Insurance Design (VBID) model test. Anthem is a strong proponent of both beneficiary choice and plan innovation, but also underscores the importance of transparency as a means to mitigate member confusion and facilitate appropriate enrollment decisions. As we have noted in previous comment opportunities, the MA VBID model test's marketing restrictions are extremely challenging in ways that would result in unintended consequences. Organizations should be rewarded for their willingness to participate in the model test and should not be limited in their ability to communicate VBID options to enrollees. In contrast, SNPs, including C-SNPs, must market to all individuals eligible to enroll in the plan. Anthem asks CMS to confirm that, consistent with current marketing guidelines, general MA plans that offer tailored supplemental benefits will have the ability to market those benefits to all eligible individuals. It is critically important to make sure that enrollees are aware of these benefits as early as possible so that they can immediately take advantage of the improved benefits. This transparency will in turn, maximize the opportunity for improved outcomes.

In a similar vein, Anthem appreciates CMS' longstanding commitment to supporting beneficiary decision-making by providing tools and materials that focus on key beneficiary purchasing criteria. Resources like Medicare Plan Finder (MPF) and 1-800-Medicare are critical to ensuring beneficiaries, caregivers, and family members are able to make informed plan choices. As CMS takes steps to improve information available through these tools, Anthem encourages CMS to clearly describe the differences between general MA plans with supplemental benefit flexibility, C-SNPs, and the MA VBI model test, and provide instructions on how beneficiaries can learn more. The increased availability of tailored benefits, combined with robust beneficiary education and appropriate marketing flexibility, will enable the MA program to continue innovating to meet members' needs.

#### Maximum Out-of-Pocket Limit for Medicare Parts A and B Services (§§422.100 and 422.101)

*Issue:* CMS proposes to amend regulations to clarify its authority to use Medicare Fee-for-Service (FFS) data to establish annual Maximum-Out-of-Pocket (MOOP) limits, and give CMS more authority to change data and methodology in setting MOOP limits.

*Recommendation Summary:* Anthem supports CMS having flexibility to set the MOOP to maintain consistent values that make sure beneficiaries can access affordable and sustainable benefits. However, we urge CMS to ensure that all technical and operational issues with encounter data are resolved before using it to calculate MOOP limits for Parts A and B services.

*Recommendation Detail:* The challenges associated with Encounter Data System (EDS) submissions are well documented and substantial.<sup>4</sup> While Anthem appreciates the activities CMS has engaged in over the last year aimed at providing feedback and technical assistance to, and soliciting input from, stakeholders as the transition to encounter data continues, challenges persist.

Given that outstanding EDS issues have significant consequences for plan payment, Anthem requests that CMS refrain from using encounter data to establish MOOP limits until CMS can certify that encounter data is complete and accurate. Anthem remains supportive of the transition to a system based fully on encounter data, and will continue to partner with CMS to ensure the encounter data submission process is properly functioning, valid, and accurate.

#### Cost-Sharing Limits for Medicare Parts A and B Services (§§417.454 and 422.100)

*Issue:* CMS proposes to amend regulation to clarify that it may use Medicare FFS data and/or MA encounter data to establish appropriate cost-sharing limits.

*Recommendation Summary:* Anthem urges CMS to ensure that all technical and operational issues with encounter data are resolved—and that encounter data is complete and accurate— before using it to establish cost-sharing limits for Parts A and B services. Further, CMS should retain flexibility for plans in designing benefit and cost-sharing structures.

*Recommendation Detail:* As noted above, Anthem remains concerned about the issues that continue to plague the encounter data system. We thank CMS for the work it has recently undertaken to address these issues, but assert that it is premature to use encounter data not just for risk adjustment purposes, but also for informing patient utilization scenarios used to help identify MA plan cost-sharing standards and thresholds that are not discriminatory. Anthem urges CMS to not use encounter data for these purposes until the Agency can certify the data is accurate and complete.

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<sup>4</sup> United States Government Accountability Office. January 2017. "Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments."



Further, while Anthem appreciates CMS' goals to prevent discriminatory benefit design, it is important to ensure that plans continue to have the flexibility to establish benefit and cost-sharing structures to ensure that beneficiaries are provided with valuable product choices.

Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review (§§422.254 and 422.256)

*Issue:* CMS proposes to eliminate the meaningful difference requirement beginning with MA bid submissions for CY 2019.

*Recommendation Summary:* Anthem supports CMS' proposal to eliminate the meaningful difference requirement.

*Recommendation Detail:* Anthem agrees with CMS' assertion that elimination of the meaningful difference requirement—along with other flexibilities proposed in this rule—will improve competition, innovation, available benefit offerings, and provide beneficiaries with affordable plans that are tailored for their unique health care needs and financial situation. We also look forward to working with CMS as it 1) aims to improve MPF and 1-800-MEDICARE to help beneficiaries easily compare multiple plans and 2) updates guidance and model materials for MA organizations to use to provide valuable information to enrollees to evaluate and select the best plan for their needs.

Coordination of Enrollment and Disenrollment through MA Organizations and Effective Dates of Coverage and Change of Coverage (§§422.66 and 422.68)

*Issue:* CMS proposes to codify the seamless conversion rules, which allow individuals to be converted from a non-Medicare plan to an MA plan when they become eligible for Medicare, with new limits.

*Recommendation Summary:* Anthem urges CMS to finalize its proposals around seamless conversion of dual eligibles into Dual Eligible Special Needs Plans (D-SNPs), with some modifications to ensure the timely and accurate transfer of data from state Medicaid programs to D-SNPs.

Anthem also recommends that CMS permit the conversion of eligible enrollees from existing non-Medicare coverage to MA coverage offered by the same organization without requiring an opt-in election process, so long as the MA coverage is high quality, can demonstrate continuity of access to the member's providers and prescription medications, and provides enhanced beneficiary notifications.

*Recommendation Detail:* Anthem supports seamless conversion and other default enrollment processes that ensure individuals continue to receive coverage from the same parent issuer from which they most recently received (or continue to receive) coverage, as we believe this enhances continuity of care.

We agree that allowing seamless conversion of duals into D-SNPs offered by the same parent organization that administers their Medicaid managed care plan will promote care integration for this vulnerable patient population. Anthem's experience with default enrollment in Tennessee indicates that care coordination models for dually-enrolled members are able to cut across traditional Medicare-Medicaid service boundaries and requirements to deliver the two programs' benefits and services in an integrated way, through one point of contact. Our care management program addresses the member's physical, behavioral health, and long-term services and supports needs—also through a single point of contact. In addition, we have undertaken extensive efforts to ensure the contracted provider network for the D-SNP is substantially similar to our Medicaid network in Tennessee, which promotes continuity of care. For all these reasons, we strongly agree with CMS that default enrollment of duals into D-SNPs offered by the affiliated Medicare Managed Care Organization (MMCO) should be permitted. Seamless

coordination between plan products and continuation of specialized care for these high-need, high-cost members will ensure that they receive the most optimal care, achieve better health outcomes, and are highly satisfied with their care experience.

As CMS moves to finalize this flexibility, Anthem urges the Agency to ensure that states have clear guidance regarding when it must approve use of this default enrollment process, as well as what type of information it must share with the MAO, and in what timeframe. To ensure that seamless enrollment is truly seamless, Anthem asks CMS to ensure that plans and states (as well as CMS itself) have clear guidance detailing their respective roles in the process, including when paperwork must be filed, and when decisions must be made. Ensuring timely and open communication between all parties will ensure the best experience for the member. Furthermore, the timing of Medicare eligibility data from the state via the Medicare Modernization Act (MMA) file will be important because if not received in the month prior to the effective date, retro-activity becomes an issue for enrollment and CMS acceptance of that enrollment. Delays in receipt and incorrect data will cause member abrasion where benefits may not activate on the correct date or notices may not be delivered to eligible beneficiaries within CMS guidelines. If incorrect information is received, determination of said enrollment may be difficult. Thus, we urge CMS to set standards for the timeliness, completeness, and accuracy of the data included in the MMA file.

Because CMS will require a commitment from a MAO to implement the default enrollment—along with Agency and state approval to do so—Anthem notes that it would be helpful if CMS provided a model contract (or the boilerplate requirements) to ensure a reasonable playing field—much like what it did as part of the Medicare-Medicaid Plan (MMP) demonstrations. In addition, we request additional clarity on CMS’ approach to identifying/determining at any time whether or not to suspend/rescind approval of the default enrollment capability if the MAO is not in compliance. While we agree with the intent of the requirement, it is important for sponsors to have clear insight into the intended structure or approach for this review.

In addition to support seamless conversion of duals into D-SNPs, Anthem is also strongly supportive of CMS’ proposal to allow for a process that would be available to all MA organizations for purposes of converting eligible enrollees from existing non-Medicare coverage to MA coverage offered by the same organization. Upon becoming eligible for Medicare, beneficiaries should be encouraged to enroll in MA, rather than be default enrolled in FFS, because MA plans offer a more coordinated approach to care compared to the fragmented coverage generally received through FFS. Unlike FFS, MA plans provide care coordination programs and disease management programs and may offer Medicare beneficiaries additional benefits to supplement their coverage. Most MA plans also provide prescription drug coverage in combination with the medical coverage.

In addition, MA plans are held to rigorous quality standards which assess member experience, how well plans keep members healthy and manage members’ chronic conditions, and compliance with CMS standards, such as call center wait times, among other factors. Notably, CMS does not measure or report on FFS quality scores the way it does for MA plans. As a result, Medicare enrollees have no way of comparing the quality of traditional FFS to available MA plan options.

Fundamentally, MA plans offer an approach to health coverage that is better for beneficiaries and for the long-term sustainability of Medicare. In fact, recent studies document that MA plans can reduce inappropriate use of services and can improve the quality and outcomes for members.<sup>5</sup>

Anthem urges CMS to finalize a seamless enrollment process that would be available to all MA organizations for purposes of converting eligible enrollees from existing non-Medicare coverage (e.g., commercial, Medicaid) to MA coverage offered by the same organization. However, we recommend that CMS eliminate the proposed opt-in election process. Anthem does not agree that an opt-in election process—even one that is simplified—is appropriate, as the main goal of default enrollment initiatives is to assist the beneficiary in having a “seamless” transfer into an MA plan. We are, however, strongly supportive of providing a beneficiary with full disclosure of their right not to enroll in the selected option before its effective date. For seamless conversion of a non-Medicare member into an MA plan, Anthem encourages that CMS require sponsors to issue multiple notices and engage in robust outreach efforts to educate the member of their right to select another option. We support advanced notification that extends beyond current requirements in order to ensure beneficiaries, their family members, and caregivers are well-informed of the seamless conversion process, coverage options, and the ability to opt out.

To further ensure beneficiary protections in this type of seamless enrollment—beyond the additional beneficiary outreach described above—Anthem also recommends that the option only be made available to MA plans that have a minimum 4-Star quality rating, and that can demonstrate continuity of provider networks and formularies between the member’s prior coverage and the new MA coverage. Anthem provides our commercial members nearing Medicare eligibility the ability to use a tool known as PlanMatch, which enables them to assess how well Anthem’s MA offerings match up with their current coverage, in terms of providers and formularies. This allows members to select the plan best equipped to continue meeting their health care needs. Requiring MA plans to be high quality and demonstrate that they can provide continuity of care will ensure that seamless conversion is in the best interest of the beneficiary.

#### Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries [§422.60(G)]

*Issue:* CMS proposes a limited expansion of its regulatory authority to initiate passive enrollment for certain dually-eligible beneficiaries in specific instances. Specifically, CMS’ proposal would add authority to passively enroll Full-Benefit Dual Eligibles (FBDEs) currently enrolled in an integrated D-SNP—who are experiencing an involuntary disruption in either their Medicare or Medicaid coverage (e.g., state re-procurement of MMCO contracts, non-renewal of D-SNP contracts)—into another “highly-integrated D-SNP” or a Fully-Integrated Dual Eligible SNP (FIDE SNP).

*Recommendation Summary:* Anthem supports CMS’ proposal to expand its authority to initiate passive enrollment. However, we recommend that CMS broaden eligibility to include all D-SNPs that have minimum quality standards and can demonstrate appropriate levels of integrated benefits.

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<sup>5</sup> See Ayanian J.Z., Landon BE, Zaslovsky AM, Saunders R, Pawlson L.G., & Newhouse JP. (2013). Quality of Ambulatory Care in Medicare Advantage HMOs and Traditional Medicare. *Health Affairs* 32 (7): 1228-1235; and Curto, V., Einav, L., Finkelstein, A., Levin, J.D., & Bhattacharya, J. (2017). Healthcare Spending and Utilization in Public and Private Medicare. NBER Working Paper No. 23090. Retrieved from <http://www.nber.org/papers/w23090> (accessed October 6, 2017); and Beveridge, R. A., Mendes, S. M., Caplan, A., Rogstad, T.L., Olson, V., Williams, M.C., McRae, J. M., & Varga, S. (2017). Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data. College of Population Health Faculty Papers. Paper 77. Retrieved from <http://jdc.jefferson.edu/cgi/viewcontent.cgi?article=1082&context=healthpolicyfaculty> (accessed October 6, 2017).

In addition, we ask CMS to provide additional clarity around the requirements an MAO will have to meet in order to be eligible to receive passive enrollment. Specifically, we request more information about how CMS will determine that the acquiring plan has substantially similar provider and facility networks and Medicare- and Medicaid-covered benefits as the plan from which the beneficiaries are passively enrolled.

*Recommendation Detail:* In order to successfully create a pathway to passive enrollment into integrated plans, CMS should expand the types of D-SNPs that are eligible to receive passive enrollment. Anthem notes that, to-date, only a limited number of FIDE SNPs and an even lesser known number of highly integrated D-SNPs are actually available in the marketplace, which may significantly limit the benefits of CMS' proposal.

We also ask CMS to share additional information about how it will assess whether networks are "substantially similar," such as whether a percentage overlap will be required and, if so, what that percentage will be.

#### Part D Tiering Exceptions [§§ 423.560, 423.578(A) and (C)]

*Issue:* CMS aims to clarify that requests for tiering exceptions should be granted to the lowest applicable cost-sharing for the tier containing preferred alternative drugs for treatment of the enrollee's health condition.

*Recommendation Summary:* Anthem appreciates CMS' efforts to clarify the tiering exceptions process, and encourages the Agency to continue providing sponsors with clear and specific guidance and examples to govern the process. We support the proposal to establish rules that base eligibility for tiering exceptions on the lowest applicable cost-sharing for the tier containing preferred alternative drugs for a particular disease state.

*Recommendation Detail:* Anthem asserts that tier exceptions should be for the same type of drug (i.e., brand to brand, and generic to generic) and thanks CMS for proposing an approach that reflects that approach. We agree that the proposed shift in regulatory policy—which would establish a distinction between non-preferred branded drugs, biological products, and non-preferred generic and authorized generic drugs—achieves needed balance between limitations in plans' exceptions criteria and beneficiary access.

#### Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries (§423.38)

*Issue:* CMS proposes to change the current continuous SEP rules for dually eligible or other subsidy eligible beneficiaries to a more limited set of rules that would apply to both Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs), such that the beneficiary has one annual opportunity to change plans. However, the beneficiary would be allowed additional SEPs in instances of passive enrollment, or if he or she experiences a change in Medicaid or LIS status.

*Recommendation Summary:* While Anthem supports efforts that are intended to promote continuity of care, we urge CMS to modify its proposal to ensure that dual eligibles are not disincentivized from enrolling in integrated MA-PD plans, like D-SNPs and MMPs.

*Recommendation Detail:* CMS should modify its proposal to prevent a disincentive for dual eligible beneficiaries from enrolling in integrated MA-PD plans. Specifically, we request that CMS continue to extend a SEP to duals for the purpose of moving to an integrated plan option, including a D-SNP or MMPs. The current ongoing monthly SEP is in the best interest of the dual eligible beneficiaries as well

as important to joint marketing strategies, viable enrollment levels, alignment of Medicare-Medicaid enrollment under one plan sponsor, and consumer choice in states where integrated care options through D-SNPs and MMPs are being promoted.

Most dually-eligible beneficiaries are enrolled in a Part D plan at the time they become dually eligible. As CMS points out, newly dually eligible beneficiaries can be initially assigned to a Part D stand-alone plan when they become 65 to assure access to Part D coverage unless they choose a plan. This initial assignment provision also applies to the bulk of people with disabilities under age 65 who become dually eligible. At the same time, most seniors are already enrolled in a PDP or MA-PD by the time they become dually eligible due to a need for Medicaid services and thus also eligible for enrollment in an integrated plan option, such as a D-SNP or MMP. Consumers are often fearful of any change of plans. Once they are already enrolled in a drug plan it is harder to get dually eligible beneficiaries to switch plans to enroll in an integrated D-SNP or MMP even though there are benefits to enrollment in the integrated programs. We believe further restriction of the current monthly SEP provision will inhibit the movement from PDPs to SNPs and/or MMPs designed specifically to serve dually eligible beneficiaries.

The SEP is an important tool for encouraging enrollment in D-SNPs and MMPs. Marketing to these individuals requires considerable effort and immediate action when the person has made up his/her mind. It appears this provision would restrict a dual beneficiary's choice to enroll in an integrated D-SNP or an MMP at a time when they may need such specialized care the most because of their medical and end-of-life care needs. Many of these enrollees cannot wait for another year to access another annual SEP for enrollment. We urge CMS to retain the SEP for enrollment into integrated options.

Any Willing Pharmacy Standards Terms and Conditions and Better Define Pharmacy Types (§§ 423.100, 423.505)

*Issue:* CMS suggests that it is “inappropriate to classify pharmacies as ‘mail order pharmacies’ solely on the basis that they offer home delivery by mail” and states that “Part D plan sponsors may not exclude pharmacies with unique or innovative business or care delivery models from participating in their contracted pharmacy network on the basis of not fitting in the correct pharmacy type classification.”<sup>6</sup>

*Recommendation Summary:* Because there is not a beneficiary access interest in ensuring that as many pharmacies as possible are able to dispense drugs by mail, the more compelling interest – beneficiary safety – should take precedence over unlimited expansion of drug home delivery services in the Part D Program. Thus, Anthem urges CMS to ensure that sponsors continue to have sufficient flexibility to implement network pharmacy criteria that is both reasonable and relevant for the Part D program.

*Recommendation Detail:* CMS' statements—which are included in preamble text rather than in proposed regulatory language—appear to be based on an inaccurate understanding of Part D network contracting, impermissibly seek to interfere with plan and pharmacy negotiations, and attempt to establish new substantive standards without appropriate opportunity for public notice and comment. CMS' guidance would place retail pharmacy business interests above Medicare beneficiary safety and compromise the ability of Part D Plan sponsors to ensure that when Medicare beneficiaries choose to receive drugs delivered to their home, they are receiving a consistent level of service, quality, and safety regardless of which pharmacy fills and delivers their drugs.

Dispensing and delivering drugs to an individual's home gives rise to unique quality, safety, privacy, and timeliness considerations as compared to retail dispensing. CMS explicitly recognized these

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<sup>6</sup> 82 Fed. Reg. 56336, 56408-09 (Nov. 28, 2017).

considerations when it considered imposing its own timely delivery standards on mail order pharmacies.<sup>7</sup> Timeliness of drug delivery is a critical factor for beneficiaries that rely on medications, and medication dispensing errors may be less easily identified without in-person pharmacist consultation. These factors make it imperative that a pharmacy offering home delivery has a closely monitored delivery mechanism and a comprehensive quality control process.

Large and highly automated mail order pharmacies that focus solely or primarily on this method of dispensing have designed processes to ensure that shipped drugs arrive timely and accurately, and have demonstrated substantially lower dispensing error rates than retail pharmacies.<sup>8</sup> By comparison, retail pharmacies with a low volume of home delivery orders necessarily have a different focus than mail order pharmacies, and there is reason for caution in allowing them to experiment with this new business line with the Medicare population. Because all mail order pharmacies deliver drugs to a member's home and typically result in a uniform level of cost-sharing, there is not the same compelling interest in access to a wide variety of mail order pharmacies as there is with retail pharmacy access. There is, however, a compelling interest in ensuring the safety and timeliness of drug delivery through the mail.

CMS' preamble statements regarding mail and retail pharmacy networks appear to be based on an assumption that Part D Plan Sponsors prohibit pharmacies from participating in their networks because they provide drugs through home delivery. This is not generally an accurate understanding of Part D pharmacy contracting practices. Rather, it is more likely that a Part D Plan Sponsor would require a pharmacy that wants to receive *payment* for drugs delivered to a Medicare beneficiary's home to meet certain terms and conditions relating to the quality, safety, and timeliness of such drug delivery as a condition of *coverage* of such drugs.

If a pharmacy is not able to meet such reasonable criteria, the pharmacy would typically only be able to receive payment for drugs delivered in the retail setting, but generally would not be entirely excluded from all of a Plan Sponsor's pharmacy network. It is well within Part D Plan Sponsor's rights – and its obligations to Medicare beneficiaries and CMS – to impose these types of standards on network pharmacies seeking coverage for drugs dispensed to Medicare beneficiaries.

Section 1860D-4 of the Social Security Act permits Part D Plan sponsors to establish “terms and conditions” as prerequisites for contracting with pharmacies and does not prohibit sponsors from establishing different standards for mail and retail pharmacy services. CMS requires that these terms and conditions must be “reasonable and relevant.”<sup>9</sup> CMS now suggests, in the preamble to the Proposed Rule, that specific terms and conditions may not be permissible, without offering any specific basis for why they are not “reasonable and relevant.”

Regardless of a pharmacy's *primary* line of business, it seems reasonable that if it is *delivering drugs to a patient's home*, it would be required meet the standards imposed by a Part D Plan Sponsor on other pharmacies that *deliver drugs to patients' homes*, particularly when such standards relate to *qualifications*

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<sup>7</sup> 79 Fed. Reg. 29844, 29857 (May 23, 2014) (“When issues with filling a prescription arise in a retail setting, the beneficiary often is notified of the problem in real time, or within hours of discovery. When issues arise in a mail order setting, the delays in finding, communicating, and making the appropriate contacts to resolve the problem may add days onto the ultimate delivery date, resulting in a potentially more significant concern for mail order beneficiaries if these delays result in gaps in therapy. . . . Many beneficiaries may be very well served by this type of pharmacy access, but only if they can rely upon efficient processing and turnaround times. Mail order pharmacies contracted by Part D sponsors can reasonably be expected to meet minimum performance standards for order fulfillment, including convenient order turnaround times, as a beneficiary protection and as a component of providing good customer service.”)

<sup>8</sup> J. Russell Teagarden, *Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice*, 25 PHARMACOTHERAPY 1629-1635 (Nov. 2005).

<sup>9</sup> 42 C.F.R. § 423.505(b)(18).

*relevant to home delivery.* CMS' preamble statements impermissibly seek to expand the statutory any willing pharmacy requirements beyond the Agency's statutory authority, in a way that inappropriately disincentivizes the imposition of high quality standards on drug delivery practices. By suggesting the inclusion of certain pharmacies in Plan Sponsor networks, CMS' suggested new rules may also violate the non-interference provision enacted by Congress, which prohibits CMS from "interfer[ing] with the negotiations between . . . pharmacies and PDP sponsors."<sup>10</sup>

Further, CMS' statements in the preamble may be interpreted as establishing additional substantive standards not currently present in existing statutes or regulations. As such, they should be proposed as specific regulatory changes to promote clarity regarding CMS' intended requirements and provide a meaningful opportunity for notice and comment. CMS' approach in the preamble to the Proposed Rule does not satisfy the procedural requirements under the Administrative Procedures Act for promulgating new substantive requirements.<sup>11</sup> Moreover, the discussion in the preamble, without clarification in the Final Rule that it does not result in new substantive requirements, may give rise to significant confusion about the applicable standards for Part D pharmacy contracting.

#### Changes to the Days' Supply Required by the Part D Transition Process (§417.484)

*Issue:* CMS proposes to change the current required days' transition supply in the outpatient setting from "30 days" to "a month's supply." The Agency also proposes shortening the required transition days' supply in the LTC setting to the same supply currently required in the outpatient setting.

*Recommendation Summary:* While Anthem supports CMS' proposed change to the days' supply in the LTC setting, we are concerned that requiring a transition fill in the outpatient setting for a supply of at least a month of medication will cause confusion and place unnecessary burden on beneficiaries, plans, and prescribers. We urge CMS to define a required number of days' supply in the outpatient setting, and to provide additional clarity about how this policy would be applied in cases when prescriptions are not filled on the first of the month.

*Recommendation Detail:* While Anthem understands that CMS' intent with this proposal is to address inquiries from Part D sponsors regarding scenarios involving medications that do not easily add up to a 30 days' supply when dispensed, we are concerned that changing the regulation from "30 days" to "a month's supply" will actually complicate the process and cause operational challenges. A month's supply can vary (i.e., a month can be 28 days, 29 days, 30 days, or 31 days), impacting how sponsors process amounts to administer in any given month, and potentially leading to inconsistent application of the

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<sup>10</sup> Social Security Act, § 1860D-11. Despite CMS' insistence that the non-interference provision is inapplicable to negotiations between Part D Plan Sponsors and pharmacies, a straightforward textual analysis of the plain meaning of the noninterference clause makes it clear that such negotiations are included within the scope of the prohibition. The text identifies the three entities ("drug manufacturers and pharmacies and PDP sponsors") which are joined together using the conjunctive "and." There is no limiting disjunctive, such as "or" or "but not," which would limit the application of the noninterference clause to certain, but not all, of the named entities. Nor is punctuation used, such as a comma, to separate some types of negotiations from others within whose negotiations CMS might possess authority to interfere. The plain meaning of the text obviously applies to negotiations between any and all of the named parties, and excludes none of them. The noninterference clause is not limited, as CMS has suggested, only to those negotiations involving drug manufacturers.

<sup>11</sup> *Am. Radio Relay League, Inc. v. F.C.C.*, 524 F.3d 227, 236–37 (D.C. Cir. 2008) (quoting *Conn. Light & Power Co. v. Nuclear Regulatory Comm'n*, 673 F.2d 525, 530–31 (D.C. Cir. 1982) ("[T]he [Administrative Procedure Act's] notice and comment requirements ensures that an agency does not 'fail[ ] to reveal portions of the technical basis for a proposed rule in time to allow for meaningful commentary' so that 'a genuine interchange' occurs rather than 'allow[ing] an agency to play hunt the peanut with technical information, hiding or disguising the information that it employs.'"); *Horsehead Res. Dev. Co., Inc. v. Browner*, 16 F.3d 1246, 1268 (D.C.Cir.1994) (internal citations omitted) ("[A]n agency also 'must 'describe the range of alternatives being considered with reasonable specificity. Otherwise, interested parties will not know what to comment on, and notice will not lead to better-informed agency decision-making.'")

policy across sponsors. Any resulting processing issues will have downstream implications for prescribers and the beneficiaries themselves. Thus, Anthem urges CMS to provide a defined number of required days' transition supply in the outpatient setting to mitigate confusion and ensure consistency across the program.

In addition, because not all beneficiaries fill their prescriptions on the first of the month through the last day of the month (some beneficiaries fill their prescriptions on the 13<sup>th</sup> of the month, for example), Anthem asks CMS to articulate how the transition process would apply in these cases. Finally, Anthem agrees that shortening the required transition days' supply in the LTC setting to the same supply currently required in the outpatient setting would simplify operations and eliminate additional drug waste and cost. We note that because LTC pharmacies are accustomed to dispensing up to a 98-day supply, Anthem encourages CMS to conduct robust educational outreach to LTC pharmacies to ensure this proposal is successfully implemented and operationalized.

Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes (§§423.100, 423.120, and 423.128)

*Issue:* CMS proposes to permit Part D sponsors to immediately remove or change the preferred or tiered cost-sharing of brand drugs, and substitute or add therapeutically equivalent generic drugs instead of, for example, in the next month. CMS would permit implementation at any time of the year so long as certain requirements are met, including that the sponsor provides direct notice of the change to beneficiaries, CMS, and other entities.

*Recommendation Summary:* Anthem greatly appreciates the additional formulary flexibility that CMS proposes to offer Part D sponsors. However, we recommend that CMS consider removing the direct notice requirement, given that it repeats information already provided in the Explanation of Benefits (EOB). If CMS does ultimately require the provision of a direct notice, Anthem asks CMS to reevaluate the need to include information regarding how members can submit a coverage or tiering exception request.

*Recommendation Detail:* CMS' proposal to allow expedited substitutions of certain generics is an important step in balancing formulary continuity with greater flexibility for Part D sponsors to make mid-year changes to formularies. However, Anthem asserts that a separate direct notice should not be required when a plan up-tiers or removes a brand drug concurrent with adding its equivalent generic. The EOB requirements ensure that members are notified of formulary changes, which applies to the brand and the addition of the equivalent generic to the formulary. Adding a separate notice mailing is redundant and will unnecessarily increase administrative costs.

If CMS finalizes the proposal with the direct notice component, we recommend that the Agency consider the unintended consequences that may result from the inclusion of information about how a coverage or tiering exception can be requested. Anthem asserts that including such language in the notice will create an expectation that a member would qualify for the exception without trying the equivalent generic. This expectation is inconsistent with current guidance as—except for narrow therapeutic drugs—the equivalent generic should treat the medical condition as well as the brand. The guidance itself provides beneficiaries with protection because it specifically limits this type of formulary change to brand drugs and their therapeutically equivalent generic drugs. Thus, removing instructions on how to request a coverage or tiering exception will mitigate member confusion, and ensure alignment with other CMS policy.



Treatment of Follow-On Biological Products as Generics for Non-LIS Catastrophic and LIS Cost-Sharing (pg. 56416)

*Issue:* CMS proposes to revise the definition of “generic drug” to include follow-on biologic products to allow a lower cost-sharing option to LIS beneficiaries and to non-LIS beneficiaries during catastrophic coverage. However, CMS notes that this change is limited and does not affect follow-on products for purposes of transition fills or mid-year formulary changes due to interchangeability concerns.

*Recommendation Summary:* Anthem supports CMS’ proposal to revise the definition of a generic drug to include follow-on biological products solely for purposes of non-LIS catastrophic cost-sharing and full LIS cost-sharing.

*Recommendation Detail:* Financial sustainability continues to be a growing concern in the Part D program. Though there is uncertainty around the prices at which biosimilars will enter the market, it is the industry’s expectation that they will have lower prices than the reference products. The Congressional Budget Office (CBO) has even estimated that biosimilar entry into the market could lead to lower drug prices over time and overall cost savings even with expanded use.<sup>12</sup> However, the current treatment of biosimilar biological products as brands for purposes of LIS cost-sharing creates a disincentive for LIS enrollees to choose biosimilars. Thus, CMS’ proposal will improve enrollee incentives to choose follow-on biological products over more expensive reference biological products, and will reduce costs to both Part D enrollees and the Part D program.

Eliminating the Requirement to Provide PDP Enhanced Alternative (EA) to EA Plan Offerings with Meaningful Differences (§423.265)

*Issue:* Effective for CY 2019, CMS proposes to eliminate the PDP Enhanced Alternative-to-Enhanced Alternative (EA-to-EA) meaningful difference requirement, while maintaining the requirement that enhanced plans be meaningfully different from the basic plan offered by a plan sponsor in a service area. CMS also indicates its future intent to reexamine how it defines the meaningful difference requirement between basic and enhanced plans offered by a PDP sponsor within a service area.

*Recommendation Summary:* Anthem supports CMS’ proposal, and requests that the Agency be transparent about—and allow sufficient stakeholder input on—any contemplated changes to the Out-of-Pocket Cost (OOPC) method used to evaluate differences between basic and enhanced plans.

*Recommendation Detail:* As CMS notes, two enhanced PDPs offered by a plan sponsor could vary with respect to their plan characteristics and benefit design, such that they might appeal to different subsets of Medicare enrollees, but in the end have similar OOP beneficiary costs. Thus, we agree with CMS that the PDP EA-to-EA meaningful difference requirement should be eliminated. We are also aligned with CMS in the belief that a meaningful difference that takes into account OOP costs be maintained between basic and enhanced plans. This will ensure that there is a meaningful value for beneficiaries given the supplemental Part D premium associated with the enhanced plans. As CMS reexamines how it defines the meaningful difference requirement between basic and enhanced plans offered by a PDP sponsor within a service area, Anthem urges the Agency to share as much information as possible about its analyses with stakeholders, and to provide a robust stakeholder input process to ensure that any changes appropriate.

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<sup>12</sup> Congressional Budget Office. June 2008. Biologics Price Competition and Innovation Act of 2007. Available here: <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/94xx/doc9496/s1695.pdf>

Request for Information Regarding the Application of Manufacturer Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale (pg. 56419)

*Issue:* CMS notes that the amount of price concessions reported as Direct and Indirect Remuneration (DIR) fees—including manufacturer rebates and pharmacy price concessions—has been increasing. While stable Part D premiums can be attributed to negotiated price concessions, CMS states the following concerns with the current “DIR construct.” “the majority of DIR fees received above the projected amount in a plan’s bid contributes to plan profits rather than reducing premiums; the desire to reduce Part D premiums may lead a sponsor to opt for higher negotiated prices with higher price concessions instead of lower net prices with lower negotiated prices; a higher negotiated price increases OOP costs, advances beneficiaries more quickly into catastrophic coverage, and shifts costs to CMS during catastrophic coverage; non-consistent application of price concessions into negotiated price creates a lack of transparency in drug costs for beneficiaries; and an advantage for plans that do not incorporate price concessions into negotiated price since they could offer lower premiums.”

With these concerns in mind, CMS seeks feedback on potential policy approaches for applying some manufacturer rebates and all pharmacy price concessions to the price of a drug at the Point of Sale (POS).

*Recommendation Summary:* Anthem appreciates CMS’ desire to address the concerns noted above. We agree that steps must be taken to address the rising costs of prescription drugs and ensure the long-term viability of the system. However, we strongly urge CMS to carefully consider the implications of the potential policy approaches described in the proposed rule before taking any additional action. Specifically, Anthem is concerned that applying manufacturer rebates and price concessions to drug prices at the POS would:

- Do nothing to address the fundamental challenges associated with prescription drug pricing;
- Translate to higher premiums for all Part D beneficiaries;
- Lead to higher costs to the federal government;
- Create an anticompetitive environment that could also increase costs; and,
- Require fundamental changes to the pharmaceutical supply chain infrastructure (an issue that pertains to all health benefit markets where cost-sharing exists, not just Part D).

*Recommendation Detail:* Anthem is committed to helping ensure members of our affiliated health plans have access to safe, effective and affordable health care, including through efforts to negotiate savings for prescription drugs. Anthem works diligently to secure the lowest net price for drugs, and our rebate revenue ultimately reduces costs for our customers and members in the form of lower premiums.

Anthem agrees that more can and should be done to address the impact that rising drug prices have on beneficiaries and other stakeholders. However, the policy options CMS considers regarding the implementation of POS rebates in Part D would do nothing to address the fundamental challenges associated with prescription drug pricing. The policy options also raise a number of significant concerns. Anthem strongly urges CMS to carefully consider the implications of such a policy change before taking additional steps on this issue.

First, the POS policies CMS is evaluating would lower OOP costs only for some beneficiaries, while increasing premiums for all beneficiaries. In fact, the impact tables contained in the proposed rule indicate that including pharmaceutical rebates at the POS could increase premiums by up to \$28 billion over the next ten years. Meanwhile, applying rebates at the POS would increase government costs by up to \$82 billion over 10 years, while decreasing manufacturer gap discounts by as much as \$29 billion over 10 years. We note that the Medicare Payment Advisory Commission (MedPAC) has also expressed concerns about any policy that requires POS rebates would increase Medicare’s costs through its effects on

premium subsidies and manufacturer discounts. Anthem urges CMS to ensure that any Part D policy changes enable plans to continue engaging in practices that have proven successful in keeping premiums for all beneficiaries low and contain costs for the government and taxpayers.

Secondly, Anthem cautions CMS to consider the potential anticompetitive implications of revealing proprietary rebate terms. Providing an estimated minimum rebate percentage at POS, as outlined in the proposed rule, could result in competitors “reverse engineering” rebate levels, resulting in anticompetitive implications that increase costs. Under this option, POS drug costs for a given Plan Benefit Package (PBP) and therapeutic class would be reduced by the average POS rebate for the PBP and class. The average POS rebate is the gross cost-weighted average of the rebates of each rebateable drug in the class. This arrangement could yield instances in which stakeholders may be able to reasonably estimate the rebate levels of others in the market. Given that rebate levels are highly proprietary (similar to hospital discounts), manufacturers would likely to be less willing to provide larger rebates to certain payers with the knowledge that other payers can obtain that information and then seek those same discounts. It is of critical importance that—similar to hospital discounts—drug discounts and rebates, on a drug-by-drug basis, remain confidential to avoid anti-competitive impacts that raise prices.

Finally, applying rebates and price concessions at the POS would require a fundamental shift in how the impacted industries operate today (not just for Part D but for all health benefit markets), creating potential for beneficiary abrasion. The approaches CMS considers would be complex to implement for CMS, plans, and stakeholders, administratively burdensome to maintain, and potentially confusing for beneficiaries. While existing CMS guidance allows Part D plans to pass through estimated rebates at POS, this option is not widely exercised for a variety of reasons. Plan contracts, IT systems, and Prescription Drug Event (PDE) submissions are not set up to implement estimated rebates at POS. For example, the current system does not easily allow for the determination of an appropriate amount to be paid at the POS based on an individual claim. It would require creating a claims system capable of accommodating varying rebate dollars at the individual drug level. In addition, CMS has not provided any detail on the estimation process and how it would be conducted, and thus there remain major concerns about false claims exposure for estimates that are not accurate. Furthermore, if a plan passes the estimated price concessions through at POS, and then it later turns out that the estimate was too high or too low, any effort to collect the overage from the beneficiary or credit them with the difference would result in significant administrative costs given the need to reprocess claims and recalculate True Out-of-Pocket (TrOOP) costs, and in creating potential abrasion.

Given these significant concerns, Anthem recommends that CMS continue to engage stakeholders in discussions aimed at identifying ways to address rising drug costs and ensure long-term sustainability of the system.

## **Medicare Advantage and Part D Prescription Drug Plan Quality Rating System**

### **Basis, Purpose, and General Applicability of the Quality Star Ratings System (pg. 56378)**

*Issue:* CMS proposes to codify the current Part C and D Star Ratings system uses, methodology, measures, and data collection beginning with the measurement periods in CY 2019, which correlate to the 2021 Star Ratings and 2022 Quality Bonus Payments (QBPs). The current Star Ratings system and the procedures for revising it would remain in place for the 2019 and 2020 Star Ratings.

*Recommendation Summary:* Anthem applauds CMS for moving towards a regulatory process for updating Star Ratings measurements and methodology, and urges CMS to finalize its proposed approach.

*Recommendation Detail:* Anthem has long asserted that an annual and formal notice and comment rulemaking process should be used to propose and finalize changes to the Star Ratings system. We thank CMS for responding to this feedback and support the proposed policy to codify Star Ratings measurements and methodology beginning with the 2019 measurement periods. Anthem agrees that having codified regulations to govern the Star Ratings will foster the transparency and predictability needed to support continued investment in quality improvement activities and, more importantly, ensure beneficiaries are able to rely upon the Star Ratings as a true measure of quality when selecting a plan.

#### Guiding Principles (pg. 56377)

*Issue:* CMS presents a set of principles to be used to make enhancements to the MA and Part D Star Ratings. The principles emphasize, among other things, alignment with the CMS Quality Strategy, stability, accuracy and reliability, transparency, and fair and equal treatment of contracts.

*Recommendation Summary:* Anthem agrees that the guiding principles outlined by CMS are appropriate. We encourage CMS to rely on these guiding principles to ensure that any future changes to the Star Ratings create meaningful quality improvement incentives and differentiate plans based on quality.

*Recommendation Detail:* Anthem recognizes CMS' efforts to increase transparency and expand dialogue with plans and other stakeholders to ensure the Star Ratings system helps beneficiaries, families, and caregivers make informed choices; incentivizes quality improvement; provides information to oversee and monitor quality; and accurately measures and calculates scores and Stars to reflect true performance. The guiding principles CMS articulates will serve an important role in ensuring that the Star Ratings system continues to encourage improved health outcomes of beneficiaries in an efficient, person-centered, equitable, and high-quality manner.

#### Contract Ratings (pg. 56379)

*Issue:* CMS proposes to continue calculating overall and summary Star Ratings at the contract level, but requests comments on whether data reporting at different levels—such as at the Plan Benefit Package (PBP) level or parent organization level—by measure would be feasible or appropriate.

*Recommendation Summary:* CMS should continue the practice of calculating Star Ratings at the contract level.

*Recommendation Detail:* CMS notes that, because beneficiaries select a plan, rather than a contract, it has considered whether data should be collected and measures scored at the plan level. Anthem appreciates this view, but notes that there are various pros and cons associated with moving towards collecting data and measuring scores at the plan level. All of the positive and negative consequences of doing so must first be thoroughly evaluated; thus, we recommend that CMS continue to calculate Star Ratings at the contract level at this time.

However, as CMS continues assessing data reporting at the PBP level, we recommend that plan-level quality reporting should be examined for *all* SNP types (not just D-SNPs), and each group of SNPs (I-SNP, D-SNP, and C-SNP) should have separate cut points for the measures. This would be similar to what CMS does today for cut points for MA-PDs and PDPs.

CMS should also provide simulation data—similar to what they have done in the past for the Categorical Adjustment Index, for example—that illustrates how PBPs would perform if quality was reported at the plan level with separate cut points. This data could also be posted on the Display Page. It will be critical

to evaluate this data in order to provide comprehensive input on the most appropriate approach to PBP-level ratings.

#### Contract Consolidations (pg. 56380)

*Issue:* CMS proposes a new set of rules for the calculation of Star Ratings for consolidated contracts: in most cases, the Star Ratings for the first and second years following the consolidation would be an enrollment-weighted mean of the scores at the measure level for all contracts (that is, consumed and surviving contracts). For the QBP rating for the first year following the consolidation, CMS proposes to use the enrollment-weighted mean of the QBP rating of the surviving and consumed contracts (which would be the overall or summary rating depending on the plan type) rather than averaging measure scores. In subsequent years after the consolidation, CMS would determine QBP status based on the consolidated entity's Star Ratings displayed on the MPF.

*Recommendation Summary:* Should CMS move forward with changing how it calculates Star Ratings for contracts that consolidate, Anthem recommends that CMS finalize the approach as proposed, effective for the 2019 measurement year (and the associated 2021 Star Ratings that are released prior to the annual coordinated election period for the 2021 contract year and used to assign QBP ratings for the 2022 payment year).

*Recommendation Detail:* Anthem appreciates the steps CMS proposes to take to ensure the Star Ratings provide beneficiaries with accurate, reliable, and timely information for enrollment decisions, and that the system truly rewards higher quality contracts. The new methodology CMS proposes to calculate a consolidated contract's Star Ratings, which will be effective for the 2019 measurement year (i.e., 2021 Star Ratings for 2022 payment), is appropriate and will adequately address differences in how data are collected and submitted for certain measures during different periods.

#### Data Sources (pg. 56382)

*Issue:* Currently, Star Ratings measures encompass data submitted directly by MAOs and Part D sponsors to CMS, surveys of MA and Part D enrollees, data collected by CMS contractors, and CMS administrative data. CMS proposes to establish Agency authority to collect quality data and require sponsors to submit data that can be reliably used to calculate ratings and measure plan performance. CMS also asks whether it should include survey measures of physicians' experiences with health and drug plans in the Star Ratings.

*Recommendation Summary:* Anthem urges CMS to refrain from incorporating physician surveys into the Star Ratings system.

*Recommendation Detail:* While Anthem agrees that providers are important stakeholders in the quality continuum, we are concerned by CMS' consideration of developing a survey to collect information on physicians' experience with plans. As we have previously noted, the subjective nature of surveys mean they are not true representations of value and performance. Physicians and other health care providers frequently state that they do not know the name or identity of the particular health plans in which their patients are enrolled, and would therefore be incapable of accurately and appropriately responding to such surveys. Furthermore, we note that providers may be employed by the health plan for which they must complete a survey, creating an unlevel playing field across different plan types and different plan/provider employment arrangements.

### Adding, Updating, and Removing Measures (pg. 56382)

*Issue:* CMS proposes specific new rules for adding, updating, and removing measures. New measures would be announced in advance of the measurement period and through the Call Letter process, and then proposed through rulemaking. New measures would be kept on the display page for a minimum of two years.

Updates to existing measures would be based on whether the change was substantive or non-substantive. Substantive changes would be announced in advance of the measurement period and through the Call Letter process, and then proposed through rulemaking. The updated measure would be on the display page for a minimum of two years. Non-substantive changes would be announced through the Call Letter process.

Finally, removal of existing measures would be announced through the Call Letter process and in advance of the measurement period.

*Recommendation Summary:* Anthem generally supports CMS' rules for adding, updating, and removing measures. However, we recommend that CMS modify its approach for updating measures due to non-substantive changes—we do not agree that changes that do not substantively change the nature of the measure should only be announced via the Call Letter. They should also be subject to rulemaking.

*Recommendation Detail:* Anthem has recommended that CMS apply all modifications to the Star Ratings on a prospective basis, and that measures and their methodology be finalized prior to the start of the measurement period in order to give plans adequate notice. This transparency is critical for plans to meet the goal for performance that CMS expects and to ensure beneficiaries are able to rely upon the Star Ratings as a true measure of quality when selecting a plan.

### Improvement Measures (pg. 56394)

*Issue:* While CMS proposes to continue the current methodology for calculating the quality improvement (QI) measures, which includes a hold harmless provision for 5-star contracts, CMS requests comments on the methodology.

*Recommendation Summary:* Anthem has several concerns with CMS' current approach to the improvement measures, and recommends that CMS adopt several changes in order to ensure that the measure rewards plans that improve their quality, while not adversely impacting consistently high-performing plans.

*Recommendation Detail:* CMS currently calculates the improvement measures in determining a contract's overall Star Rating using a methodology that calls for either inclusion of both QI measures or exclusion of both QI measures. However, the current approach can potentially penalize plans who have consistent high performance in either the Part C or Part D group of measures, year over year.

For example, if Plan A had high performance for Part C measures in Year 1 and maintained that high performance in Year 2, the QI calculated for the Part C QI would be approximately zero change, thus earning Plan A a 3 Star for the QI measure rating. Given that the QI measures (C31 and D07) have a weighting value of 5, this 3 Star negatively effects Plan A's Overall Star Rating. To allow plans the ability to benefit from quality improvement without penalty in the other Part C or D group of measures, CMS should calculate plans' Star Ratings separately for Part C and Part D with and without the improvement measures to first determine if the corresponding QI measure should be included in the overall Star Rating calculation. Currently, the "hold harmless" methodology accounts for both QI

measures together. A more appropriate approach would therefore be for CMS to calculate MA plans' Overall Star Ratings separately for Part C and Part D with and without the improvement measures to first determine if the corresponding QI measure should be included in the overall Star Rating calculation. We propose the following revision for MA-PD contracts:

- 1) Calculate the overall rating for MA-PD contracts with just the Part C improvement measure.
- 2) Calculate the overall rating for MA-PD contracts with just the Part D improvement measure.
- 3) Calculate the overall rating for MA-PD contracts *without* including either the Part C or the Part D improvement measures.
- 4) Calculate the overall rating for MA-PD contracts *with both* the Part C and Part D improvement measures.
- 5) If an MA-PD contract in any steps 1 through 4 has four (3.75) or more Stars, CMS should use that overall rating—otherwise, CMS should use the overall rating from step 4.

*Example: Plan A (additional details included in the attached document “Partial QI Harmless Example”)*

- Step 1: Overall rating with just Part C improvement measure = 3.783
- Step 2: Overall rating with just Part D improvement measure = 3.628
- Step 3: Overall rating without either improvement measure = 3.681
- Step 4: Overall rating with both improvement measures = 3.727
- Step 5: Use overall rating from Step 1 (include only the Part C improvement measure) = 3.783

CMS' methodology for how the QI measures are calculated (C31 and D07) should also be modified to include measures for which plans achieved and maintained at least 4 Stars in the “held harmless” category. Though CMS compares year-over-year performance for all QI-eligible measures, the “hold harmless” provision only applies to those measures for which a plan scored 5 Stars for both years in the comparison (and are therefore deemed by CMS to be “not applicable” to the QI calculation). This deviates from the general rule CMS follows for “held harmless,” where plans earning 4 Stars or higher are deemed “high performing.” Including measures with 4 Stars in both years would be a more appropriate approach. Anthem recommends that CMS either adjust its methodology and assign “not applicable” when determining “Improvement, Decline, or No Change” (see Column U in the QI template) for measures that increased in Star Ratings for year two of the comparison, or add these measures to the “held harmless” provision. Because the “held harmless” provision is tied to raw rates, and does not take into account the actual Star Rating earned (except in cases when a plan earned a 5 Star Rating in the prior year)—combined with the fact that CMS' uses a clustering methodology for the cut points—a plan can improve its “earned” Star Rating while its raw rate declines year-over-year. This can lead to a “significant decline” in the QI calculation. For example: Plan A earned a 4 Star on the complaints measure (CTM) with a rate of 0.088 in 2017, and earned 5 Stars with a CTM rate of 0.142 in 2018. Because a lower score on this measure is preferable to a higher score, Plan A actually had a higher complaint rate in 2018, but earned a higher Star Rating. Since the QI calculation is based on raw rate performance, it results in a “significant decline.” We urge CMS to implement our recommended modification to this component of the methodology.

Furthermore, all MA plans that are subject to the improvement measure should be allowed to benefit from it. Anthem does not support any proposal that would limit the application of the improvement measure to only those plans with Star Ratings greater than 2.5 Stars (or any other minimum threshold). Limiting the measure to only plans with more than 2.5 Stars goes against the objective of the improvement measure in encouraging and rewarding improvements in performance, particularly among lower-rated plans. This is important because plans with 2.5 Stars may have a disproportionate share of members who are low income, have low health literacy, or who are otherwise vulnerable and more difficult to reach. As a result,

these plans may be struggling to make strides in the Star Ratings and should not be further disadvantaged by being excluded from the improvement measure.<sup>13</sup>

Finally, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) measure should be removed from the improvement factor calculation because survey data are based on respondents' perceptions of their health status and thus are not a true reflection of plan performance or members' outcomes. Plans should not be judged on perceptions, but rather on objective and clinically relevant outcomes. We also note that CMS has had challenges with its CAHPS vendor in recent years, particularly around sample selection, causing us to appeal our results as not statistically valid. If performed inconsistently, the improvement comparison will not be valid—further emphasizing the importance of excluding CAHPS and HOS measures from this calculation.

#### Data Integrity (pg. 56394)

*Issue:* CMS proposes to codify existing rules for the reduction of measure ratings when CMS identifies incomplete, inaccurate, or biased data that have an impact on the accuracy, impartiality, or completeness of data used for the impacted measures. The Agency also proposes a new rule for scaled reductions for appeals measures, based on the degree to which Independent Review Entity (IRE) data are missing.

*Recommendation Summary:* Anthem supports CMS' proposal to scale reductions for the appeals measures when there are data integrity issues. However, Anthem urges the CMS to provide additional information about how it will ensure equity between plans that are audited and plans that are not.

*Recommendation Detail:* Anthem supports CMS' high standards and agrees that it is appropriate to take reasonable steps to ensure data integrity in the Star Ratings. We continue to believe that distinguishing between plans that may have an occasional data error versus plans that have significant, material errors due to major systemic issues is critical when assessing and rating plans based on the integrity of their data. However, we note that the current policy results in inequity because audited plans' Star Ratings are evaluated against the Star Ratings of plans that are not audited. It is important that CMS structure implementation of this policy to adjust for any bias against plans that are audited versus plans that are not audited to ensure a level playing field in the market.

#### Measure-Level Star Ratings (pg. 56397)

*Issue:* While CMS proposes a continuation of existing policy to establish cut points with use of clustering methodology for non-CAHPS measures and use of relative distribution and significance testing for CAHPS measures, the Agency seeks comment on potential changes to the cut point methodology.

*Recommendation Summary:* Anthem strongly recommends that CMS restore the predetermined thresholds as they provide valuable stability and enable plans to track both expectation and actual achievement.

*Recommendation Detail:* Given the significance of the Star Ratings on beneficiary enrollment decisions and plan payment, Anthem continues to believe that sponsors need better information to benchmark performance and focus improvement efforts. We therefore commend CMS for seeking input on the most appropriate methods for determining the cut points. Specifically, we recommend that CMS reinstate predetermined 4-Star thresholds. Removing the thresholds placed undue emphasis on relative

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<sup>13</sup> ASPE. "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Payment Programs." December 21, 2016. Available at: <https://aspe.hhs.gov/pdf-report/reportcongress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>. Accessed on February 20, 2017.



performance among plans, and not on whether a plan achieves the desired level of performance or quality. Anthem would also support a methodology that minimizes year-to-year changes in the cut points by setting caps on the degree to which a measure cut point could change from one year to the next. Reinstating this kind of transparency and stability not only aligns with the guiding principles CMS describes for the Star Ratings, but facilitates plans' collaboration efforts with provider networks by setting quality expectations and performance targets.

#### Categorical Adjustment Index (CAI) (pg. 56404)

*Issue:* CMS proposes to codify the current calculation and use of the CAI that adjusts for the average within-contract disparity in performance associated with the percentages of beneficiaries who receive a low-income subsidy and/or are dual eligible and/or have disability status. CMS will continue to announce the set of measures for adjustment for determination of the CAI during the Call Letter process while measure stewards continue examining measure specifications and the Assistant Secretary for Planning and Evaluation (ASPE) completes its research and formalizes final recommendations.

*Recommendation Summary:* CMS must continue to work with plans and other stakeholders to identify a meaningful, long-term solution to the impact of Socio-economic Status (SES) and disability status on Star Ratings.

*Recommendation Detail:* Anthem agrees that beneficiary-level characteristics have a meaningful impact on Star Ratings and that it is critical to allow plans that care for the program's most vulnerable beneficiaries to compete on an equal playing field. However, in our experience, the CAI is insufficient to address this important problem. CMS has also acknowledged that the CAI has a very small impact on plan ratings.

Thus, Anthem urges CMS to continue working with plans to identify a long-term solution to the impact of dual status and SES on Star Ratings. Anthem appreciates CMS' ongoing attention to and focus on the impact of beneficiary-level characteristics—specifically, dual status and socio-economic factors—on plan performance. We understand that the CAI is a temporary solution, but we urge CMS to work quickly to evaluate the options recently proposed by ASPE and develop a longer-term, meaningful fix.

#### Plan Preview of Star Ratings (pg. 56407)

*Issue:* CMS proposes to have plan preview periods before each Star Ratings release, consistent with current practice.

*Recommendation Summary:* Anthem supports CMS' proposal to continue having plan preview periods, but encourages CMS to release Star Ratings on or before August 15 each year.

*Recommendation Detail:* Historically, CMS uploads the Star Ratings to [www.medicare.gov](http://www.medicare.gov) by mid-October. Anthem requests that new Plan Ratings Fliers be made available on or before August 15 in order to ensure current year ratings are included by October 1 – along with the enrollment application, summary of benefits, and multi-plan insert as required by the Medicare Marketing Guidelines (MMG). This will ensure plans have sufficient time to include the most up-to-date information in member-facing materials, which will reduce beneficiary confusion and facilitate the enrollment process.

## **Improving the CMS Customer Experience**

### Restoration of the Medicare Advantage Open Enrollment Period (§§422.60, 422.62, 422.68, 423.38 and 423.40)

*Issue:* CMS proposes to include regulatory provisions that reflect open enrollment changes required by the 21<sup>st</sup> Century Cures Act. The statute eliminates the current MA disenrollment period (i.e., for MA enrollees to leave MA and return to Original Medicare in the first 45 days of the year) and replaces it with an Open Enrollment Period (OEP) from January 1 to March 31 of each year that would allow a one-time election to switch plans or disenroll from an MA plan for Original Medicare. Individuals who use the new OEP to make changes to MA coverage may also enroll in or disenroll from Part D.

The 21<sup>st</sup> Century Cures Act also prohibits unsolicited marketing and mailing marketing materials to individuals eligible for the new OEP. CMS proposes to use a “knowing standard” to “effectuate the statutory provision and to avoid against overly broad implementation.”

*Recommendation Summary:* As CMS works to implement the legislatively-mandated new OEP, Anthem encourages CMS to lead a robust beneficiary outreach and education initiative. We also ask CMS to maintain the current MMG definition of “unsolicited marketing materials” for the OEP.

*Recommendation Detail:* It is critical that beneficiaries are well-informed of the rules and parameters of the new OEP, including whether they are eligible and what types of enrollment decisions that they can make during the period. As mitigating confusion and potential disruption in coverage should be CMS’ top priorities, Anthem requests that the Agency provide additional insight into how it plans to ensure beneficiaries are fully aware of the enrollment changes and their rights and responsibilities. We stand ready to assist CMS in this effort.

Anthem appreciates the steps CMS is taking in an effort to address the difficulties sponsors will likely face in aiming to limit marketing to only those individuals who have not yet enrolled in a plan during the OEP (i.e., the “knowing standard”). We recommend that CMS clarify that the standard only applies to unsolicited contact as currently defined in the MMG. It is critical that plans have clear guidance so as to maintain compliance with CMS requirements.

### Reducing the Burden of the Compliance Program Training Requirements (§§422.503 and 423.504)

*Issue:* CMS proposes to eliminate both the CMS-developed compliance training and the requirement that employees at First-tier, Downstream, and Related-entities (FDRs) of Part C and Part D plan sponsors receive compliance training.

*Recommendation Summary:* CMS should maintain the current regulatory guidance requiring FDRs to complete compliance training, and continue to require FDRs to use standard CMS-issued training materials, but implement modifications to the training content. In addition, CMS should clarify in guidance how certain stakeholders may be deemed exempt from training requirements if they are a participating provider/supplier in Medicare Part A or Part C.

*Recommendation Detail:* CMS’ proposed change to eliminate the Agency’s developed compliance training, along with the requirement that FDRs complete the training, is concerning. By removing these requirements, Anthem is concerned that CMS is sending inappropriate signals to FDRs regarding their compliance and Fraud, Waste, and Abuse (FWA) responsibilities, which could have negative downstream consequences for beneficiaries and the Medicare program more broadly.

Anthem has found the CMS training helpful both to administer adequate training and to ensure that our FDRs have met Medicare program requirements. The ability to use training materials developed by CMS allows for a consistent approach to FDR training and sets clear expectations for how FDRs need to maintain compliance. Though CMS proposes to remove the requirement that plan sponsors provide compliance training to their FDRs, CMS notes that it will continue to hold sponsors accountable for the failures of their FDRs to comply with Medicare program requirements. Anthem agrees that compliance and FWA training is an essential part of sponsors' compliance programs and is an important tool to educate and ensure FDRs are aware of Medicare program requirements. CMS' regulatory guidance is the backbone of FDR oversight programs and lays out the compliance program requirements that flow down to FDRs. However, removing the requirement could lead to confusion among FDRs about what is required of their employees and inconsistent or insufficient understanding of Medicare requirements, potentially increasing compliance risks across the program.

Anthem urges CMS to maintain the current regulatory guidance requiring FDRs to complete training, and to continue to require FDRs to use standard CMS-issued training materials. However, CMS should create more user-friendly training content for FDRs. Specifically, CMS should create one training deck that combines General Compliance and FWA training requirements (instead of the current two separate trainings) and make the content widely available in an easy format for FDRs to access and incorporate into their current training systems. The current tool CMS uses to issue training content, the Medicare Learning Network (MLN), is frequently cited as overly cumbersome for large FDRs to use and access. Additionally, to reduce the burden of training requirements on hospitals, suppliers, health care providers, pharmacists, and physicians (all of which may be considered FDRs), CMS should clarify in guidance how such stakeholders may be deemed from training requirements if they are a participating provider/supplier in Medicare Part A or Part B. Anthem urges CMS to clarify if a facility's deeming status applies to its employees and downstream entities. If this is the case, then these such stakeholders can be exempt from training requirements.

#### Revisions to Timing and Method of Disclosure Requirements (§§422.111 and 423.128)

*Issue:* CMS proposes to revise plan offering disclosure requirements such that MAOs and Part D sponsors would have to provide the necessary information by the first day of the Annual Election Period (AEP). In addition, CMS proposes to revise existing regulatory language to allow for the distribution of the Evidence of Coverage (EOC), summary of benefits, and provider network information on a web site or via electronic delivery, so long as notice is provided of the availability of paper copies on request.

*Recommendation Summary:* Anthem supports CMS' proposal to change timing requirements. We encourage CMS to take a similar approach as with the formulary last year, allowing both MAOs and Part D sponsors who choose to provide access to an electronic versions of the provider directory/pharmacy directory and formulary, as well as the EOC, to provide a single combined hard copy notice for all three documents. Anthem suggests disclosures be made in the same fashion and only to those who had received the original communication needing correction. If this policy is finalized, Anthem urges CMS to release detailed sub-regulatory guidance in February so plans have adequate time to implement. Guidance should include confirmation that the allowance of distribution of the summary of benefits via web site or electronic delivery is for existing member mailings, and not for the summary of benefits that are provided with a printed enrollment form at the time of enrollment.

*Recommendation Detail:* Beneficiaries receive large amounts of mail during the AEP, and sorting and navigating through the various documents can be challenging and overwhelming. Providing a streamlined Renewal (Plan Annual Notice of Change – ANOC) and Welcome experience without the distraction of a 250+ page EOC, while providing members instructions on how to receive an EOC if they want one, will improve member satisfaction and reduce administrative cost burden for health plans.

Revisions to Parts 422 and 423, Subpart V, Communication/Marketing Materials and Activities (pg. 56433)

*Issue:* CMS proposes to include a definition for “communications,” which would be broad, as marketing is now defined. At the same time, CMS proposes to narrow the definition of “marketing” as the “use of materials or activities by MA or Part D sponsors intended to draw a beneficiary’s attention to a plan, or influence a beneficiary’s decision-making process when making a plan selection or influence a beneficiary’s decision to stay enrolled in a plan.”

In addition to its proposal to distinguish between overall communications and marketing activities, CMS also proposes to break out the prohibitions on marketing activities into categories—those applicable to all communications, and those specific to marketing and marketing materials. Marketing and marketing materials would be subject to the more stringent requirements (including the need for submission to and review by CMS). Those materials not considered marketing would fall under the less stringent communication requirements.

*Recommendation Summary:* Anthem appreciates CMS’ proposal to move to a more targeted review of materials related to beneficiary enrollment, and encourages CMS to further refine the definition of “marketing” to include materials or activities targeting “prospects” and not current beneficiaries.

*Recommendation Detail:* Overall, this proposal, if refined per the above, will provide clarity to MAOs and be a less burdensome approach to how MAOs communicate with their members.

Lengthening Adjudication Timeframes for Part D Payment Redeterminations and IRE Reconsiderations (§§423.590 and 423.636)

*Issue:* CMS proposes to change the timeframe for issuing decisions on payment redeterminations, including payment requests at the IRE reconsideration level of appeal, from 7 to 14 calendar days from the date that the sponsor receives the request.

*Recommendation Summary:* Anthem supports CMS’ proposal to lengthen the payment redetermination timeframe.

*Recommendation Detail:* The proposed longer timeframe means sponsors will have an improved ability to collect all the documents needed to support a request which will, in turn, decrease the need to deny payment redeterminations due to missing information. Anthem also agrees with CMS’ assertion that the timeline change will reduce the number of untimely payment redeterminations that must be auto-forwarded to the IRE. More importantly, the longer time frame will ensure that sponsors are able to devote resources to ensuring that all decisions are based on the most comprehensive information, which should ensure that beneficiaries are less likely to be subject to decisions that ultimately need to undergo further appeal.

Elimination of Medicare Advantage Plan Notice for Cases Sent to the IRE (§422.590)

*Issue:* CMS proposes to remove the plan requirement to notify a beneficiary when a case is forwarded to the IRE.

*Recommendation Summary:* Anthem urges CMS to move forward to finalize the elimination of this requirement.

*Recommendation Detail:* Because the Part C IRE is contractually responsible for notifying an enrollee that it has received and will be reviewing the enrollee's case, the plan notice is duplicative and nonessential. Anthem agrees that it is appropriate for the IRE to be responsible for notifying enrollees upon forwarding all cases.

E-Prescribing and the Part D Prescription Drug Program; Updating Part D E-Prescribing Standards (§423.160)

*Issue:* CMS proposes to adopt the National Council for Prescription Drug Programs (NCPDP) SCRIPT version 2017071 as the official Part D E-Prescribing standard for certain specified transactions. The NCPDP SCRIPT 10.6 standard would, in turn, be retired from use in Part D.

*Recommendation Summary:* Anthem supports CMS' proposal to adopt version 2017071 of the NCPDP SCRIPT as the electronic standard to be used by Medicare Part D plans.

*Recommendation Detail:* Adoption of the NCPDP SCRIPT version 2017071 will improve efficiency, accuracy, and user satisfaction with the E-prescribing system, as well as communication between stakeholders involved in E-prescribing.

Reduction of Past Performance Review Period for Applications Submitted by Current Medicare Contracting Organizations (§§422.502 and 423.503)

*Issue:* CMS proposes to reduce the past performance review period from 14 months to 12 months. This proposal would establish a review period from March 1 of the year preceding the application submission deadline through February 28 of the year in which the application is submitted.

*Recommendation Summary:* Anthem supports CMS' proposal to reduce the past performance review period from 14 months to 12 months.

*Recommendation Detail:* Anthem agrees that a 12-month look-back period is fairer and more accurate than the current 14-month period, which leads non-compliant actions that occur during the first two months of year to be counted against an organization in two consecutive past performance review cycles, while non-compliant actions occurring in all other months would only be counted in one review cycle. A 12-month period would ensure that non-compliance would not be double counted.

Part D Prescriber and Part C Provider Preclusion List (pg. 56441 and §422.224)

*Issue:* CMS proposes to eliminate the prescriber enrollment requirement, which was scheduled to take effect on January 1, 2019, and to instead require plan sponsors to reject claims for Part D drugs prescribed by providers on a preclusion list.

Similarly, CMS proposes to eliminate the provider enrollment requirement (also scheduled to take effect in 2019) and impose a preclusion list requirement. MAOs would be prohibited from making payments for an item or service furnished by an individual or entity on the preclusion list, for both basic and supplemental benefits.

*Recommendation Summary:* While Anthem supports CMS' proposed elimination of the Part D prescriber and Part D provider enrollment requirements and creation of the preclusion list, we ask CMS to provide significantly more information about how this list would be created, maintained, and operationalized. We also ask CMS to confirm that MAOs will retain the right to require providers and suppliers offering services to beneficiaries be enrolled in Medicare per our contracts.

*Recommendation Detail:* Given ongoing concerns about the burden associated with CMS’ enrollment requirements, as well as the potential for negative downstream implications for beneficiaries, we agree with CMS’ decision to eliminate those requirements. While the preclusion list should mitigate many stakeholder’s previous concerns, Anthem requests that CMS develop, in consultation with plans, providers, and other stakeholders, more detailed guidance on how the preclusion list would actually function.

Anthem also asks that CMS confirm that elimination of the federal provider enrollment requirement will not bar MAOs from requiring providers to be enrolled in Medicare as a requirement of our contracts with them.

#### Removal of Quality Improvement Project for MAOs (§422.152)

*Issue:* CMS proposes to remove the requirement that MAOs develop and implement Quality Improvement Projects (QIPs), but notes that it will retain all other Quality Improvement (QI) Program requirements, including those related to the Chronic Care Improvement Program (CCIP).

*Recommendation Summary:* Anthem supports CMS’ proposal to remove QIP requirements.

*Recommendation Detail:* No longer requiring MAOs to develop and implement QIPs will reduce redundant or duplicative requirements, and allow MAOs to remain focused on existing health improvement initiatives, such as Star Ratings program metrics. Anthem agrees that these initiatives—more than the QIP—appropriately incentivize MAOs to focus on desired improvements and outcomes.

#### Reducing Provider Burden – Comment Solicitation (§422.310)

*Issue:* CMS solicits stakeholder feedback on the nature and extent of the burden facing providers of producing medical record documentation for risk adjustment purposes and ideas to address the burden.

*Recommendation Summary:* Anthem urges CMS to uphold laws that support the MA risk adjustment system, and to modify regulatory language and guidance to improve the risk adjustment data validation process. In addition, to help facilitate access to medical records, CMS should require providers (or allow MAOs to require, through their contracts with providers) to provide MAOs access to electronic medical records systems. Finally, we ask CMS to take steps to simplify and streamline provider directory requirements.

*Recommendation Detail:* CMS is required, by law, to adjust payments to MA organizations for their enrollees’ risk factors, such as age, disability status, gender, institutional status, and health status. To this end, MA organizations are required in regulation to submit risk adjustment data to CMS to characterize the context and purposes of items and services provided to enrollees. Risk adjustment data that is submitted must be documented in the medical record and MA organizations are required to submit medical records to validate the risk adjustment data. Thus, MAOs may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. As CMS evaluates ways to reduce provider burden, Anthem encourages CMS to hold up these laws and requirements to ensure a functional and accurate risk adjustment system.

In addition, Anthem notes that 42 CFR 422.310(e) states: “Validation of risk adjustment data. MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data.”

Anthem requests that CMS revise this language, as follows (proposed revisions in italics), to support the risk adjustment data validation process: “*Validation of risk adjustment data. MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS or at the request of the MA organization. There may be penalties for submission of false data. Providers may not seek reimbursement for the cost of these medical records requests and shall respond to such requests within thirty (30) calendar days.*”

Furthermore, to facilitate access to medical records, CMS should require providers to provide MAOs access to electronic medical records systems. Alternatively, CMS should allow MAOs to contract with providers and include this requirement as a term of the contract. Anthem notes that this may require coordination with other agencies to ensure such access is compliant with privacy and security rules.

Finally, while Anthem supports CMS’ ongoing focus on ensuring provider directories are accurate for Medicare beneficiaries and their caregivers, we continue to have significant concerns with the corresponding expectations and requirements put forth by CMS, including the burden they place on providers. We agree that timely dissemination of comprehensive and correct consumer information is important and thus continually work to ensure a high-quality consumer experience. However, CMS’ current rules around the information required in MA plan directories, the timeframe for directory updates, and quarterly outreach to providers for validation are overly burdensome and duplicative, detrimentally impacting plans, providers, and beneficiaries. The outbound outreach in particular has caused significant process and operational work impacting our ability to focus on more proactive provider education and communication campaigns. In addition, since providers receive these inquiries not just from Anthem, but from other MAOs as well, this creates a significant administrative burden that leads to provider abrasion. Anthem’s goal is to limit duplicative transactions and streamline processes impacting providers. Anthem believes a more efficient process would be for CMS to require providers to submit updates directly to CMS and to make this data available to MAOs. Providers have a higher level of responsiveness to CMS and this centralized process would eliminate the need for duplication of administrative queries to providers from multiple plans versus queries from a singular point of contact.

## **Implementing Other Changes**

### Reducing the Burden of the Medicare Part C and Part D Medical Loss Ratio Requirements (§§422.2430, 423.2430, 422.2460, and 423.2460)

*Issue:* CMS is proposing changes to the treatment of expenses for fraud reduction activities in the Medicare Medical Loss Ratio (MLR) calculation. CMS proposes to include compliant Medication Therapy Management (MTM) programs in the definition of Quality Improvement Activities (QIA) and is also proposing to reduce the current MLR reporting burden such that the Medicare MLR reporting requirements would be limited to a fewer number of data fields.

*Recommendation Summary:* Anthem appreciates CMS’ responsiveness to industry concerns over the MLR calculation and supports CMS’ proposed changes.

*Recommendation Detail:* We have long asserted that excluding all fraud reduction activities from the definition of QIA, as well as limiting the amount of fraud reduction expenses that may be included in incurred claims as part of the MLR calculated, was an inappropriate approach. Insurers’ anti-fraud programs contribute to improving the quality of health care for enrollees and are not just about recouping paid claims. As such, Anthem is pleased that CMS is proposing to broadly include MAOs and Part D sponsors’ expenses attributable to fraud prevention programs as quality improvement expenses for purposes of the MLR.

Furthermore, we agree that allowing Part D sponsors to include compliant MTM programs as QIA in the calculation of the Medicare MLR will encourage sponsors to strengthen their MTM programs by implementing innovative strategies for vulnerable populations, leading to better medication adherence and improved outcomes.

#### Late Contract Non-Renewal Notifications (§§422.506, 422.508, and 423.508)

*Issue:* CMS proposes to clarify that any non-renewal requests submitted after the first Monday in June will be treated as a request for CMS to agree to mutually terminate the contract.

*Recommendation Summary:* Anthem seeks clarification on whether this change would affect the notification requirements for members and/or other processes for non-renewing plans and, if so, we encourage CMS to issue new non-renewal guidance as soon as possible. We also ask CMS to clarify that this change would not prohibit MAOs from expanding or marketing other plans in the service area in which one of its plans was terminated or non-renewed.

*Recommendation Detail:* While we appreciate CMS' efforts to clarify the late contract non-renewal process, we ask that the Agency simultaneously take steps to ensure that non-renewal guidance is shared with plans as soon as possible. This will help MAOs address potential late requests, and provide beneficiaries with more notice about the impact of a non-renewal in their area.

In addition, Anthem urges CMS to keep in mind that unforeseen circumstances beyond the plan's control (e.g., state regulatory requirements) may drive a late contract non-renewal. Thus, we recommend that CMS clarify that this policy change would not impact a plan's ability to expand into new states.

#### Eliminate Use of the Term "Non-renewal" to Refer to a CMS-Initiated Termination (§§422.506, 422.510, 423.507 and 423.509)

*Issue:* CMS is proposing to remove the term "CMS initiated non-renewal" and define the term "non-renewal" to include actions initiated by the plan sponsor (and not by CMS). Actions initiated by CMS would be referred to as terminations.

CMS will maintain its requirements that enrollees be notified by mail at least 90 days prior to the effective date of a non-renewal. Additionally, CMS will require that enrollees be notified at least 90 days before the December 31 effective date of a contract termination when CMS makes the determination to terminate the agreement with the plan sponsor by August 1st of the same year.

*Recommendation Summary:* We ask CMS to clarify if this change would prohibit MAOs from expanding or marketing other plans in the service area in which one of its plans was terminated or non-renewed. CMS should also clarify how this change would be displayed on Medicare.gov.

Anthem supports CMS' proposal to maintain the number of days required to notify enrollees of a plans' termination or non-renewal.

*Recommendation Detail:* Given that the proposed rule does not address how the contemplated policy change would impact a sponsor's ability to expand or market other plans in the service area in which another plan was terminated or non-renewed, we ask CMS to provide greater insight into how those rules would apply.



We also note that Chapter 11 of the Medicare Managed Care manual includes the following definitions of a CMS initiated non-renewal. Anthem asks CMS to indicate whether items A, C, and D would be revised in CMS guidance to fall under the “termination” definitions.

*Reasons for CMS non-renewal of a contract include the following:*

- a) The MA organization has not fully implemented or shown discernable progress in implementing quality improvement projects;*
- b) For any of the same reasons that CMS would terminate a contract;*
- c) The MA organization has committed any of the acts that would support imposition of intermediate sanctions or civil money penalties; or*
- d) The MA organization did not submit a benefit and price bid or the benefit and price bid was not acceptable.*

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We appreciate this opportunity to provide input on the CY 2019 MA and Part D proposed rule. We are eager to work with CMS to ensure the delivery of robust benefits and quality care via these important programs. Should you have any questions or wish to discuss our comment further, please contact Christine Harhaj at 212.476.1744 or [Christine.Harhaj@Anthem.com](mailto:Christine.Harhaj@Anthem.com) or Leah Hirsch at 202.508.7881 or [Leah.Hirsch@Anthem.com](mailto:Leah.Hirsch@Anthem.com).

Sincerely,



Anthony Mader  
Vice President, Public Policy

Enclosure: Partial QI Harmless Example

Star Rating Final

				Plan A			
Category	Source	Star Measure	2016 Weight			Rate	Star
Part C:							
HEDIS	HEDIS	C01: Breast Cancer Screening	1.0			65.00%	3
	HEDIS	C02: Colorectal Cancer Screening	1.0			66.00%	3
	HEDIS	C07: Adult BMI Assessment	1.0			92.00%	4
	HEDIS	C09: Care for Older Adults - Medication Review	1.0			N/A	N/A
	HEDIS	C10: Care for Older Adults - Functional Status Assessment	1.0			N/A	N/A
	HEDIS	C11: Care for Older Adults - Pain Assessment	1.0			N/A	N/A
	HEDIS	C12: Osteoporosis Management in Women who had a Fracture	1.0			30.00%	2
	HEDIS	C13: Diabetes Care - Eye Exam	1.0			60.00%	2
	HEDIS	C14: Diabetes Care - Kidney Disease Monitoring	1.0			89.00%	3
	HEDIS	C15: Diabetes Care - Blood Sugar Controlled	3.0			78.00%	4
	HEDIS	C16: Controlling Blood Pressure	3.0			72.00%	3
	HEDIS	C17: Rheumatoid Arthritis Management	1.0			77.00%	3
	HEDIS	C21: Plan All-Cause Readmissions	3.0			10.00%	3
	HEDIS	C20: Medication Reconciliation Post Discharge	0.0			N/A	N/A
SNP HRA	HEDIS	TBD: Hospitalizations for Potentially Preventable Complications	0.0			N/A	N/A
	Part C Rptg	C08: Special Needs Plan (SNP) Care Management	1.0			N/A	N/A
HOS	HOS	C04: Improving or Maintaining Physical Health	3.0			71.00%	4
	HOS	C05: Improving or Maintaining Mental Health	3.0			89.00%	5
	HEDIS / HOS	C19: Improving Bladder Control	0.0			N/A	N/A
	HEDIS / HOS	C06: Monitoring Physical Activity	1.0			49.00%	3
CAHPS	HEDIS / HOS	C18: Reducing the Risk of Falling	1.0			47.00%	1
	CAHPS	C03: Annual Flu Vaccine	1.0			75.00%	4
	CAHPS	C22: Getting Needed Care	1.5			85.00%	4
	CAHPS	C23: Getting Appointments and Care Quickly	1.5			78.00%	4
	CAHPS	C24: Customer Service	1.5			80.00%	1
	CAHPS	C25: Rating of Health Care Quality	1.5			86.00%	4
	CAHPS	C26: Rating of Health Plan	1.5			80.00%	2
Complaints	CTM	C27: Care Coordination	1.5			89.00%	5
	CTM	C28: Complaints about the Health Plan	1.5			0.29	3
Appeals	IRE	C32: Plan Makes Timely Decisions about Appeals	1.5			N/A	N/A
	IRE	C33: Reviewing Appeals Decisions	1.5			N/A	N/A
Disenrollment	CMS Admin	C29: Members Choosing to Leave the Plan	1.5			13.00%	4
Compliance	CMS Admin	C30: Beneficiary Access and Performance Problems	1.0			100	5
Call Center	CMS Admin	C34: Call Center - Foreign Language Interpreter and TTY Availability	1.5			99.0%	5
Improvement	Star Ratings	C31: Health Plan Quality Improvement	5.0			0.660	5
Part C Weighted Star Points:							163.00
Part C Weight:							44.50
Part C Summary Rating (Unrounded):							3.663
Reward Factor (i-Factor):							0.0
Part C CAI Value:							
Adjusted Part C Summary Rating (Unrounded):							3.663
Adjusted Part C Summary Rating (Rounded):							3.50
Part D:							
Clinical Rx	PDE	TBD: High Risk Medication	3.0			8.00%	4
	PDE	D11: Medication Adherence for Diabetes Medications	3.0			79.00%	4
	PDE	D12: Medication Adherence for Hypertension (RAS antagonists)	3.0			81.00%	5
	PDE	D13: Medication Adherence for Cholesterol (Statins)	3.0			79.00%	5
MTM CMR	Part D Rptg	D14: MTM Program Completion Rate for CMR	1.0			25.1%	2
CAHPS	CAHPS	D08: Rating of Drug Plan	1.5			78.00%	1
	CAHPS	D09: Getting Needed Prescription Drugs	1.5			89.00%	3
Complaints	CTM	D04: Complaints about the Drug Plan	1.5			0.29	3
Appeals	IRE	D02: Appeals Auto-Forward	1.5			2.50	5
	IRE	D03: Appeals Upheld	1.5			N/A	N/A
Disenrollment	CMS Admin	D05: Members Choosing to Leave the Plan	1.5			13.00%	4
Compliance	CMS Admin	D06: Beneficiary Access and Performance Problems	1.0			100	5
Call Center	CMS Admin	D01: Call Center - Foreign Language Interpreter and TTY Availability	1.5			98.0%	5
MPF	CMS Admin	D10: MPF Price Accuracy	1.0			99.0	4
Improvement	Star Ratings	D07: Drug Plan Quality Improvement	5.0			0.008	3
Part D Weighted Star Points:							111.50
Part D Weight:							29.00
Part D Summary Rating (Unrounded):							3.845
Reward Factor (i-Factor):							0.0
Part D MA-PD CAI Value:							
Adjusted Part D Summary Rating (Unrounded):							3.845
Adjusted Part D Summary Rating (Rounded):							4.00
Overall:				w. C QI	w. D QI	w.o. 2 QI	w. 2 QI
Overall Weighted Star Points:				244.00	234.00	219.00	259.00
Overall Weight:				64.50	64.50	59.50	69.50
Baseline Overall Rating (Unrounded):				3.783	3.628	3.681	3.727
Reward Factor:				0.0	0.0	0.0	0.0
Overall Rating (Unrounded):				3.783	3.628	3.681	3.727
Overall Rating (Held Harmless):							3.783
Overall CAI Value:							
Final Overall Rating (Unrounded):							3.783
Adjusted Overall Rating (Rounded):							4.00