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March 5, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Submitted via www.regulations.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter (CMS-2017-0163)

Dear Administrator Verma:

Thank you for the opportunity to comment on the CY 2019 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and draft Call Letter (CMS-2017-0163). Independent Health Association (IHA) is a not-for-profit health plan that continually aims to provide our Western New York community with innovative health-care products and services, which enable affordable access to quality health care. Our award-winning customer service, dedication to quality health care and unmatched relationships with physicians and providers has allowed us to be consistently recognized as one of the highest-ranked health insurance plans in the nation. Additionally, IHA's contracts each received an overall star rating of 4.5 in the 2018 star ratings. IHA offers Medicare Advantage Plans and Prescription Drug Plans. Please see our comments below.

Attachment II Changes in the Part C Payment Methodology for CY 2019

Section G

MA Employer Group Waiver Plans (EGWP)

CMS proposes to fully transition in 2019 to using only individual market plan bids to calculate the bid-to-benchmark (B2B) ratios to set EGWP payments.

IHA believes a better approach would be to maintain the payment methodology that was applied in calculating the 2017 and 2018 MA EGWP payment rates for 2019. Maintaining this payment methodology would allow for stability in group premium rates, which would benefit group beneficiaries. Moreover, since CMS will not be announcing bid-to-benchmark ratios for 2019 until the 2019 Rate Announcement, we do not have the information necessary to make a full assessment of the proposal at this time. Therefore, we believe it would be better to defer the transition to using only individual market plan bids to set EGWP payments until there can be a full understanding of the impact.

Attachment VI Draft CY 2019 Call Letter

Section I – Parts C and D

Enhancements to the 2019 Star Ratings and Future Measurement Concepts

Proposed Scaled Reductions for Appeals IRE Data Completeness Issues

IHA thanks CMS for recognizing that there are varying degrees of data completeness issues and this merits a methodology for reductions in star ratings that reflects the degree of the data accuracy issue for a contract, rather than a "one-size-fits-all" approach. We support the methodology that would employ scaled reductions in star ratings based on the degree of missing/compromised IRE data as well as CMS intent to employ multiple data sources and to address small sample size and other methodological safeguards.

New Measures for 2019 Star Ratings

Statin Use in Persons with Diabetes (SUPD) (Part D)

IHA supports the weighting of 1 for the first year of this measure. This will allow time to work with physicians and gain some experience with the membership prior to the weighting of the measure going to 3, as an intermediate outcome measure, in subsequent years.

Statin Therapy for Patients with Cardiovascular Disease (Part C)

IHA supports the weighting of 1 as a process measure in the 2019 Star Ratings and recommends that this measure continue as a process measure and retain a weight of 1 in subsequent years beyond 2019.

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

CMS proposes to begin displaying the CMP icon (or other type of notice) on Plan Finder for the 2019 Annual Election Period (AEP) for any sponsoring organization that receives a CMP in 2018 (or receives a CMP for a 2017 Program Audit). Beginning in 2019, CMS proposes that regular updates would occur throughout the year.

In the interest of transparency, it is good for beneficiaries to know about CMP's. Transparency can help a beneficiary avoid making a choice they may later regret. However, this only happens when the transparency is easily interpreted by the consumer. When transparency is not easily interpreted by consumers, it can create more questions and confusion, and could be detrimental to the process of a beneficiary selecting the plan that is right for them. The root cause of a CMP is explained by CMS to the Medicare Advantage Organization's CEO in the form of an enforcement letter. CMS intends to possibly link Medicare Plan Finder to the enforcement letter. The enforcement letter is not a letter that is written with the consumer in mind and can be very easily misinterpreted. In these situations, the desired outcome of a better understanding of the violation could have the unintended consequence of more confusion.

For beneficiaries who only see the icon and do not attempt to understand the root cause of the violation, all violations may appear to be equal, which is simply not true. Some violations are substantially more impactful than others. If an icon is present, it will appear to the beneficiary that CMS considers these to be the same level of egregiousness. If the goal is "to enable beneficiaries to make an informed enrollment decision," CMS may wish to consider only having an icon if the transgression affected a certain percentage of the overall plan membership, there was a high level of severity associated with the infraction (e.g. systemic), and the magnitude of the CMP was large-scale.

Audit of the Sponsoring Organization's Compliance Program Effectiveness

CMS is considering allowing sponsoring organizations that have recently undergone a program audit to treat the program audit as meeting the annual compliance program audit requirement for one year from the date of the CMS program audit. When a CMS program audit is conducted, IHA agrees that having a Compliance Program Effectiveness audit is duplicative, in light of the extensive compliance operations review that occurs during a program audit. We also agree that if CMS finalizes this proposal, there would be a reduction in burden on sponsoring organizations.

Section II – Part C

Total Beneficiary Cost (TBC)

CMS is considering the elimination of the current TBC evaluation in future years, subject to statutory and regulatory limitations or changes. IHA supports eliminating the TBC in future years and believes this would accomplish the stated goal of promoting innovation, improving available benefit offerings, and providing beneficiaries with affordable plans better tailored to their health care needs.

CMS rightly works to control the growth of beneficiary costs. However, the implementation of TBC can have unintended effects of plans choosing not to improve benefits so that the TBC constraints can be met. Rather than an artificial pricing constraint, Medicare beneficiaries who do not see value in premium and cost sharing increases or benefit decreases will choose to go to another plan. Where there is robust competition in many markets, this will help keep the premiums in check. If CMS believes that to be insufficient, it could establish "guardrails" that would trigger additional justification.

Maximum Out-of-Pocket (MOOP) Limits

Again in 2019, CMS will leave the voluntary MOOP at $3,400 and the mandatory MOOP at $6,700. The purpose of having a voluntary MOOP is to give plans more flexibility with their cost sharing levels. CMS does not allow any additional benefit cost share flexibility if the MOOP is $3,401 -$6,699. There could be more incentive for Medicare Advantage Organizations to have a MOOP other than at $6,700 if the copay differentials that are permitted between voluntary and mandatory MOOP were enough to justify having a lower MOOP. IHA suggests that CMS utilize a MOOP sliding scale, similar to what was done between the Part D deductible and the Tier 5 maximum cost sharing. In that case, the higher the deductible, the lower the Tier 5 copay must be. In this way, beneficiaries who usually do not hit their MOOP would still be able to benefit from some reduced cost sharing.

Health Related Supplemental Benefits

CMS is considering changing supplemental benefits by broadening the definition of what is "primarily health related." IHA believes this will provide more benefit flexibility when a plan chooses to offer this coverage and urge CMS to follow-through on this proposal. We look forward to detailed future guidance on this topic, not only regarding the nature of benefits

(such as the illustrative list currently in the Medicare Advantage Manual), but also on the requirement for an order by a "licensed provider as part of a care plan...".

Uniformity Flexibility

Conceptually, IHA believes having uniformity flexibility in benefits tied to health status or disease state is a very good idea. Flexibility to address the health care needs of particularly vulnerable beneficiaries can—and should—be accomplished without the risk of discriminatory effects which CMS notes. We look forward to additional guidance and details on this proposal, and the implementation of a CMS mailbox to take questions from plans for the 2019 plan year.

Section III – Part D

Formulary Submissions

CY 2019 Formulary Reference File (FRF)

IHA supports moving the release of the summer update window from July to August, and we recommend having the window close in mid-August to allow for sufficient time for formulary printing. As CMS states, moving the summer update window from July to August would allow for the inclusion of newly approved drugs to the formulary, and would reduce the number of drugs that would appear on the future year's February FRF release. This will lead to more accuracy and consistency between the current and future year formulary files regarding the removal of brand drugs and the addition of any new drugs. This would also reduce the amount of formulary changes and negative change requests that would occur during the first couple of formulary submissions for the future year.

Changes for CY2019 Formulary Submissions

IHA supports the proposal for removing the NDS supplemental file from the formulary submission. We are in agreement with the reasoning provided in the Call Letter, that the NDS supplemental file has been operationally challenging and a burden to maintain, outweighing any benefit. Moreover, as CMS points out, plans will continue to identify any drugs for which they impose a one month supply limit in their PBP submissions.

Improving Drug Utilization Review Controls in Medicare Part D

Concurrent DUR

Days Supply Limits for Opioid Naïve Patients

IHA supports a 7-day supply limit. We believe there are circumstances where an acute supply of an opiate prescription requires longer treatment than 3 to 5 days. We ask CMS to define what criteria constitutes an initial fill. We also ask CMS to define the requirements regarding transition fills for these drugs when applicable. Transition supplies are required when the plan cannot distinguish ongoing versus new therapy. Because claims history would not be available for new members from another parent organization, we ask that CMS define expectations of plan sponsors as far as whether plan sponsors are to treat these initial fills as ongoing therapy and allow up to a 30-day supply transition fill.

Thank you again for the opportunity to comment and thank you for considering IHA's views on the CY 2019 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and draft Call Letter (CMS-2017-0163). If there are any questions or additional information is needed, please contact Jeremy Laubacker at Jeremy.Laubacker@independenthealth.com.

Sincerely,

Robert Tracy
Senior Vice President, Government Programs