

January 16, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (Published in the Federal Register Vol. 82, No. 227 on November 28, 2017)

To Whom It May Concern:

On behalf of Tufts Health Plan (THP), we appreciate the opportunity to provide comments on the proposed Medicare Advantage program (Part C) regulations and Prescription Drug Benefit program (Part D) regulations, released by the Centers for Medicare and Medicaid (CMS) on November 28, 2017.

Since 1979, Tufts Health Plan has been committed to providing a higher standard of health care coverage and to improving the quality of care that its network providers deliver for every member. Tufts Health Plan's Medicare Advantage (MA) Organization, Tufts Medicare Preferred (TMP), offers Medicare Advantage Prescription Drugs Plans, Stand Alone Prescription Drug Plans and Special Needs Plans. Our Tufts Medicare Preferred HMO earned a 5 star rating from CMS for 2018.

We appreciate the opportunity to provide CMS with comments on the proposed Part C and Part D regulations. A summary of Tufts Health Plan's comments follows:

1. Tufts Health Plan appreciates the additional flexibility with respect to cost sharing limits for Medicare Parts A and B Services proposed at §§ 417.454 and 422.100 and urges CMS to issue additional clarification on these changes.
2. In implementing the changes required under the 21st Century Cures Act, we, urge CMS to identify a comparable opportunity for plans achieving 5-star status in order to maintain incentives for plans to put the effort and resources into achieving 5 stars.
3. Tufts Health Plan appreciates CMS taking steps to simplify the process at § 422.66(d)(5) to convert existing non-Medicare coverage to MA coverage offered by the same organization and we look forward to working with CMS to further clarify this process.
4. We welcome the reinstatement of seamless conversion at §§ 422.66 and 422.6 and look forward to additional guidance on the collaboration between CMS state Medicaid agencies.
5. We strongly urge CMS to take action to regulate Field Marketing Organizations (FMO) in this proposed rule and in sub-regulatory guidance.
6. We thank CMS for proposing specific new rules for adding, updating and removing measures in advance of the measurement year.

7. We respectfully request that CMS consider benchmarks that are independent of cluster analysis for measure level Star ratings.
8. Tufts Health Plan strongly supports CMS' proposal to improve member communications by proposing to narrow the definition of marketing at §§ 422.2260(b) and 423.2260(b).
9. We thank CMS for proposing to streamline the physician incentive plan stop loss requirements.

Our comments are further explained below:

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

The regulation proposes a new interpretation of statutory provisions in Sections 1852(d) and 1854(c), as well as at § 422.100(d) for 2019, to permit MA organizations to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, as long as similarly situated enrollees are treated the same and CMS determines that the plan design is not discriminatory. Tufts Health Plan appreciates CMS providing flexibility for MA organizations to structure enrollee cost sharing and other services to encourage enrollees with particular clinical conditions to consume high-value clinical services under the MA program. Patient-centered innovative benefit designs promote better health and outcomes by focusing on prevention, early detection, and care management; reducing beneficiary costs; addressing the needs of low-income beneficiaries and individuals with disabilities; and applying clinical best practices to increase patient safety and to limit unnecessary utilization of services. To avoid potential future uncertainties, we urge CMS to include regulatory text in the Final Rule that supports the flexibility that will be allowed in the MA uniformity requirements. Further, we strongly recommend that this new interpretation be extended to Part D benefits. Enabling plans to offer comprehensive care that covers both medical services and drug benefits would provide beneficiaries with access to high quality care tailored to meet their individual holistic care and needs.

In the Preamble, CMS indicates that for CY 2019, the agency is considering issuing guidance to clarify the flexibility that MA plans would have to offer targeted supplemental benefits. We support CMS's plans to provide this guidance. We recommend that CMS also provide guidance about other permissible flexibilities, including the offering of enhanced benefits and reduced cost sharing and deductibles based on objective criteria.

Lastly, Tufts Health Plan respectfully requests additional guidance on whether and, if so, how this change would impact Value Based Insurance Design (VBID) offerings currently provided as well as how CMS would expect MA organizations to market the benefits for enrollees meeting specific medical criteria. Specifically, we urge CMS to clarify in sub-regulatory guidance that it will be at the MA organization's discretion as to whether or not these tailored benefit designs are marketed to enrollees.

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

We acknowledge that CMS must implement the open enrollment changes required by the 21st Century Cures Act. The statute eliminates the current MA disenrollment period and replaces it with an open enrollment period 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. However, we have significant concerns that the proposed regulations may inadvertently degrade the value of MA plans with 5-star ratings. Currently, high quality MA organizations are granted year-round open enrollment. In

implementing the changes required under the 21st Century Cures Act, we, therefore, urge CMS to identify a comparable opportunity for plans achieving 5-star status in order to maintain incentives for plans to put the effort and resources into achieving 5 stars.

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

Opt-In Election Process

Tufts Health Plan appreciates CMS taking steps to simplify the process at § 422.66(d)(5) to convert existing non-Medicare coverage to MA coverage offered by the same organization. The proposed rule would establish, through sub-regulatory guidance, a new and simplified opt-in election process that would be available to all MA organizations. We agree that the MA organization has a significant amount of the information from the member's non-Medicare enrollment, so this new election process has the potential to make enrollment easier for a newly-eligible beneficiary to complete and for the MA organization to process. We look forward to working with CMS to further define this process in sub-regulatory guidance.

Seamless Conversion

We welcome the reinstatement of seamless conversion at §§ 422.66 and 422.6. As with the proposed changes to the process at § 422.66(d)(5), which would allow conversion of existing non-Medicare coverage to MA coverage offered by the same organization, allowing MA organizations to seamlessly convert certain dual eligible beneficiaries into D-SNPs will significantly improve the enrollment process for these newly-eligible beneficiaries. In implementing these processes, we recommend that any collaboration between state Medicaid agencies and their federal counterparts provide clarity on how enrollment requirements, including timelines, will align between the Medicaid and Medicare programs.

Changes to the Agent/Broker Compensation Requirements (§§ 422.2274 and 423.2274)

Consistent with Tufts Health Plan's prior comments on this matter, we strongly urge CMS to take action to regulate FMOs in this proposed rule and in sub-regulatory guidance. With the growing complexities of compensation expectations of individual brokers, FMOs, and the advent of private exchanges, we ask that CMS revisit regulatory guidance issued for broker commissions to assure there is not an increasing administrative burden on plans. We believe we have experiences and insights that would help reduce administrative burden on plans, lower costs, and maintain an appropriate broker commission level. We urge CMS to provide additional opportunities for stakeholder engagement and collaboration on broker commissions through modernization of 42 CFR §§ 422.2274 and 423.2274.

With respect to FMOs, we specifically request that CMS investigate current compensation and administrative fees charged by FMOs for exchanges. This area lacks formal CMS guidance, which we find to be problematic and is resulting in rapidly increasing costs for plans. In addition, the costs are highly variable from plan to plan creating potential incentives for behavior of FMOs not necessarily favoring beneficiaries or prioritizing their needs to find an appropriate plan. We request that CMS provide specific guidance in the short-term to avoid actions which curtail beneficiary choice.

Medicare Advantage and Part D Prescription Drug Plan Quality Rating System

Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)

We thank CMS for proposing specific new rules for adding, updating and removing measures in advance of the measurement year and for providing for more frequent communication points with MA

organizations to keep them apprised of forthcoming modifications. By announcing new measures in advance of the measurement period and through the Call Letter process and then proposing them in subsequent rulemaking, MA organization would have sufficient time to build processes for documentation and to train the appropriate medical staff to track and report on new or modified measures. This approach fosters stability and transparency in the Star Ratings System and supports plan and provider value-based arrangements that include quality and performance metrics that would need to be assessed and/or modified with the addition of new measures or changes to existing measures.

We appreciate CMS specifying that new measures will be kept on the display page for a minimum of 2 years (or longer if reliability and validity issues are identified), as it is critical that new measures be fully defined, tested, and validated by measure stewards prior to being considered for Star Ratings. We therefore further recommend that CMS include regulatory text that indicates that new measures must be fully defined, tested and validated by measure stewards prior to inclusion on the display page.

Measure-Level Star Ratings (§§ 422.166(a) and 423.186(a))

The proposed rule would continue CMS' existing policy to establish cut points with use of clustering methodology for non-CAHPS measures and the use of relative distribution and significance testing for CAHPS measures. We respectfully request that CMS consider benchmarks that are independent of cluster analysis. As average scores of a particular measure rise, decreased variability and tight clustering of plan performance occurs. This translates insignificant changes in percentile scores into large impacts on Star Ratings which calls into question the validity of the measure. Mathematical significance does not always equal significant quality of care.

Revisions to Parts 422 and 423, Subpart V, Communication/Marketing Materials and Activities

Amending the Regulatory Definition of Marketing and Marketing Materials (§§ 422.2260(b) and 423.2260(b))

Tufts Health Plan is grateful for CMS' proposal to improve member communications by proposing to narrow the definition of marketing at §§ 422.2260(b) and 423.2260(b). We strongly support the proposed definition of marketing as the "use of materials or activities that meet the following:

1. By the MA organization [or Part D sponsor] or downstream entities;
2. Intended to draw a beneficiary's attention to a MA [or Part D] plan or plans;
3. Influence a beneficiary's decision-making process when making a MA [or Part D] plan selection or influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing)."

We also appreciate CMS amending the list of materials that are considered to be "marketing materials" and those that are not. As CMS notes in the proposed rule, the current definition of "marketing" and the list of "marketing materials" is overly broad and has inappropriately resulted in a number of documents being classified as marketing materials. The proposed changes will significantly improve beneficiary communications as well as streamline administrative processes for both CMS and MA organizations.

Physician Incentive Plans - Update Stop-Loss Protection Requirements (§ 422.208)

§ 422.208 proposes three changes to existing guidance: (1) new per-patient deductible limits for stop-loss coverage; (2) a methodology for updating deductible limits and notes that updates may be contained in other guidance, and (3) to allow for use of non-MA members in determining physician group panel size, and to permit use of other stop-loss protection arrangements that are actuarially

equivalent to that required by 422.208(f)(iiii) and (v). We thank CMS for proposing these changes as they will streamline the physician incentive plan stop loss requirements, maintaining effectiveness while at the same time making them less burdensome.

Further, we agree that the number of a physician group's non-risk patients should be taken into account when setting stop loss deductibles for risk patients. Expanding the panel size provides the appropriate flexibility.

We thank you for consideration of our responses and look forward to continuing to work with HHS on these matters.

Sincerely,



Kristin Lewis
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Tufts Health Plan