

March 5, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2017-0163
P.O. Box 8013
Baltimore, MD 21244

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model (Issued December 27, 2017); and 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 (Issued February 1, 2018)

To Whom It May Concern:

On behalf of Tufts Health Plan (THP), we appreciate the opportunity to provide comments on Part I and to Part II of the 2019 Advance Notice and Call Letter, released by the Centers for Medicare and Medicaid (CMS) on December 27, 2017 and February 1, 2018, respectively.

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 the below comments on the 2019 Advance Notice and Call Letter. A summary of Tufts Health Plan's comments follows:

1. Tufts Health Plan urges CMS to calculate the 2019 benchmarks in the Final Notice by excluding individuals with Part A-only coverage from the calculation.
2. Tufts Health Plan is concerned with the proposed data years to determine the normalization factor; we urge CMS to use 2011 through 2017 data.
3. While Tufts Health Plan remains fully committed to the submission of complete and accurate Medicare Advantage encounter data to CMS, we continue to have concerns with any increase to the use of encounter data until data issues are resolved.
4. Tufts Health Plan strongly supports the new interpretation of "primarily health related" with respect to provision of supplemental benefits.

5. Tufts Health Plan commends CMS for permitting Medicare Advantage Organizations (MAOs) to offer flexible, value-based benefit designs that encourage enrollees with chronic conditions to use high-value clinical services.
6. We appreciate CMS providing opportunity for comment on potential changes to possible Star Ratings enhancements for 2020 and beyond. We offer specific comments on those proposals below.
7. While we appreciate the intent of moving the summer formulary update window is to allow for additional late-summer formulary updates, Tufts Health Plan has significant concerns about the implications of such a change.
8. Tufts Health Plan respectfully requests clarification on the rationale and process for conducting outlier tests on sponsors who choose a co-pay structure for the non-preferred drug tier.

Our comments are further explained below:

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

Section B. Calculation of Fee for Service Cost

Consistent with the comments CMS received on the 2018 Advance Notice, Tufts Health Plan urges CMS to calculate fee-for-service (FFS) spending based on beneficiaries enrolled in *both* Part A and Part B, rather than based on beneficiaries in either Part A or Part B. Expenditures for beneficiaries enrolled only in Part A should not be included in the calculation of the FFS benchmarks.

We strongly believe that the adjustment recommended by the Medicare Payment Advisory Commission (MedPAC) is appropriate in all geographies, and not just in Puerto Rico.¹ Beneficiaries are required to be enrolled in both Part A and Part B in order to enroll in Medicare Advantage. Those beneficiaries enrolled in Part A-only had lower Part A spending than those enrolled in both Part A and Part B. Moreover, this issue is becoming more important. A growing number of beneficiaries are enrolled in Part A only, growing nationally to 12.4 percent of all FFS beneficiaries in 2015 from 10.2 percent in 2009. MedPAC expects this rate to continue growing with the popularity of MA as an option for seniors because “as more beneficiaries enroll in MA, those beneficiaries remaining in FFS are less likely to have enrolled in both Part A and Part B.” Accordingly, we urge CMS to calculate the 2019 benchmarks in the Final Notice by excluding individuals with Part A-only coverage from the calculation.

In addition to the policy rationale for changing such a calculation given the different cost profile and increasing numbers of Part A only Medicare beneficiaries, we urge CMS to consider the legal analysis attached to the comment letter submitted by America’s Health Insurance Plans (AHIP). AHIP’s legal analysis demonstrates that, under a plain reading of the Social Security Act, CMS should calculate benchmarks using claims experience only for individuals with Medicare Parts A and B.

¹ Medicare Payment Advisory Committee. Report to the Congress; Regional Variation in Medicare Part A, Part B, and Part D Spending and Service Use. Issued September 2017. Available at: http://www.medpac.gov/docs/default-source/reports/sept17_regionalvariation_report_final_sec.pdf?sfvrsn=0.

Section L. Normalization Factors*L1. Normalization for the CMS-HCC Model (p. 38)*

For 2019, CMS proposes a Part C normalization factor of 1.041 for the CMS-HCC model used for payment in 2017 and 2018, and 1.038 for the proposed “Payment Condition Count” model, which would result in a 2.3 percent payment reduction to Medicare Advantage plan payments from 2018. This resulting decrease in risk scores will impact the premium amounts and benefits provided to enrollees.

Tufts Health Plan is concerned with the proposal to only include 2013 through 2017 risk scores to calculate the normalization factor, as the 2016 and 2017 risk scores appear to be outliers for both the 2017 model and the PCC model compared to data from 2011 to 2015. These large increases in the average fee-for-service (FFS) risk scores for both 2016 and 2017 appear to be stemming from the introduction of ICD-10 codes that occurred on October 1, 2015, suggesting that the normalization factors calculated by CMS are more of an artifact of the difference between ICD-10 and ICD-9 mapping to the HCCs, and coding differences in ICD-10 vs. ICD-9, than a real indication of higher risk scores in FFS Medicare. Consequently, we strongly recommend CMS use 2011 to 2017 data to determine the normalization factor. Further, as a general principle, we would urge CMS to use more data points in order to have more stable estimates of normalization. Using the 2013 to 2017 data points runs the risk of over normalizing for 2019 by setting the normalization factor too high. We are concerned that CMS is placing too much weight on the ICD-10 codes by not using the 2011 and 2012 data points to estimate the normalization trend.

L2. Normalization Factor for the PACE Model; L3. Normalization Factor for the ESRD Dialysis Model; L4. Normalization Factor for ESRD Post-Graft Model (p. 38-40)

Consistent with our comments above on the CMS-HCC model, we urge CMS to utilize 2011 to 2017 data points for the functioning graft and PACE model normalization factors as well as for the dialysis and post-graft models.

Section N. Encounter Data as a Diagnosis Source for 2019 (p. 42-43)

The 2019 Advance Notice and Call Letter addresses the use of encounter data in risk adjustment, proposing to increase the blend of encounter data from 15 percent in 2018 to 25 percent in 2019. CMS is also proposing to supplement encounter data-based risk scores with inpatient diagnoses submitted to RAPS. In addition, CMS is further proposing to use only encounter data in the 2019 Payment Condition Count (PCC) risk model, which would be phased in over the four-year period 2019 to 2022 by increasing the percent of the new risk model by 25 percentage points each year. While we remain fully committed to the submission of complete and accurate Medicare Advantage encounter data to CMS, we continue to have concerns with any increase to the use of encounter data until data issues are resolved.

We appreciate that the transition to weighing encounter data more was somewhat paused in 2018 to obtain input from individual Medicare Advantage plans about technical and operational issues with EDS, but, if CMS plans to continue to incorporate encounter data for risk scores, and especially if the plan is to rapidly phase out the submission of diagnosis codes through the RAPS files, then CMS must address reoccurring data infrastructure problems. Data infrastructure issues negatively impact the analysis and reporting of data, which are resulting in data that is inaccurate and unreliable.

In addition, we are concerned that timely reporting has not yet been established between CMS and the MAOs, which has limited the MAOs' ability to better understand the financial impact and accuracy of using encounter data to develop risk scores. Given these operational and technical issues, we appreciate that CMS recently provided MAOs with additional time to submit encounter data by effectively extending the final submission deadlines in 2016, 2017 and 2018. We ask that CMS formalize and communicate similar extensions for future periods until the issues are fully resolved. The extensions should be established to provide MAOs and CMS with the maximum amount of time to correct encounter data issues, but without causing a delay to the timing of CMS payments.

We also ask that CMS prioritize addressing data issues, share a detailed plan as to the usage of encounter data, undertake regular reporting of encounter data submissions, release a timeline of reporting and enforcement actions, and provide increased guidance and technical assistance to plans prior to implementing audit processes.

Attachment IV. Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2019

Section II – Part C

Health Related Supplemental Benefits (p. 182-183)

Under Section 1852(a)(3) of the Social Security Act, Medicare Advantage plans can offer supplemental benefits that are “healthcare benefits.” The 2019 Advance Notice and Call Letter proposes to expand the scope of the primarily health related supplemental benefit standard. Under the new interpretation, in order for a service or item to be considered “primarily health related,” it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.

Tufts Health Plan appreciates and strongly supports this new interpretation of “primarily health related.” This clarification will provide MA plans the flexibility necessary to provide benefits focusing directly on an enrollee’s healthcare needs, improving both quality of life and health outcomes. We look forward to working with CMS’ as further guidance is developed in advance of bid submissions.

Medicare Advantage (MA) Uniformity Flexibility (p. 184-185)

CMS indicates in the Advance Notice and Call Letter that, through the Medicare Advantage and Part D proposed rule for 2019, it has determined that providing access to services, or specific cost-sharing and/or deductibles for services or items, that is tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly is consistent with the uniformity requirement in the MA regulations at §422.100(d). MAOs would, therefore, be permitted to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees are treated the same and enjoy the same access to these targeted benefits.

As we stated in our comments on the 2019 Medicare Advantage and Part D proposed rule issued on November 28, 2017, Tufts Health Plan strongly supports CMS providing flexibility for MAOs to structure enrollee cost-sharing and other services in a manner that would 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 uncertainties, we continue to recommend that CMS provide more detailed subregulatory guidance, including clarification with respect to marketing rules for these new benefit designs.

Star Ratings (Section I)

Forecasting to 2020 and Beyond; Potential Changes to Existing Measures (p. 145-147)

Transitions of Care (Part C)

Tufts Health Plan appreciates the opportunity to provide feedback on the new HEDIS Transitions of Care measure in advance of inclusion on the display page. The proposed measure includes the following four indicators:

1. Notification of Inpatient Admission;
2. Receipt of Discharge Information;
3. Patient Engagement After Inpatient Discharge; and
4. Medication Reconciliation Post-Discharge.

CMS plans to propose to include this measure with the four indicators on the 2020 display page for possible inclusion in the 2022 Star Ratings.

We have concerns that this measure may not be ready for inclusion on the display page by 2020 as the specifications require additional clarification from NCQA. Consequently, we urge CMS to allow additional time for evaluation.

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

Tufts Health Plan has significant concerns with the expansion of the Assessment of Care for People with Multiple High-Risk Chronic Conditions beyond Medicare SNPs. Hybrid measures, such as this, are administratively burdensome to MA plans and identifying all necessary components in the medical record would be challenging. We urge CMS to limit the scope of this new measure to Medicare SNPs.

Depression Screening and Follow-Up for Adolescents and Adults (Part C); Unhealthy Alcohol Use Screening and Follow-Up (Part C); Adult Immunization Measure (Part C)

The 2019 Advance Notice and Call Letter proposes three potential new Electronic Clinical Data System (ECDS) measures for inclusion on the display page as soon as 2020: Depression Screening and Follow-Up for Adolescents and Adults (Part C), Unhealthy Alcohol Use Screening and Follow-Up (Part C), and Adult Immunization Measure (Part C). We urge CMS to closely review the challenges and limitations with using electronic clinical data before implementing additional ECDS measures.

Further, with respect to the Adult Immunization Measure, we urge CMS to develop a registry for vaccines before moving this measure to the display page. Without access to a registry where MA plans could validate vaccine administration prior to the beneficiary's enrollment with the plan, collecting information for this measure would be very administratively burdensome.

Reducing the Risk of Falling (Part C)

This current measure, collected through the Medicare HOS, assesses the percentage of beneficiaries who discussed falls, balance concerns, or walking with their healthcare provider and received fall risk intervention(s) from the provider. NCQA made two changes to this measure. The revised questions will be first collected in 2018. As a result of this, there will be no data for this measure for the 2019 Star Ratings. CMS proposes to add it to the 2020 display page and intend to add it for the 2021 Star Ratings.

We respectfully request that this measure be kept on the display page for both 2020 and 2021 Star, at a minimum, prior to consideration for possible inclusion in 2022 Star Ratings. In the proposed Medicare Advantage and Part rule released on November 28, 2017, CMS stated that measures with substantive changes would be kept on the display page for a minimum of 2 years. We believe the new denominator criteria expands the population covered which, according to CMS, indicates a substantive change.

Section III – Part D**Formulary Submissions***CY 2019 Formulary Reference File (p. 194-195)*

CMS proposes to offer a summer formulary update window and to publish an update to the Formulary Reference File (FRF) in order to allow for (1) the addition of drugs new to the summer release of the FRF, and (2) the submission of certain negative changes on brand drugs. CMS further proposes to move the summer update window later into the summer to include newly approved brands and generics that occur in July and into August.

While we appreciate the intent of moving the summer update window is to allow for additional late-summer formulary updates, Tufts Health Plan has significant concerns about potential delays to the formulary and contract approval. Pushing this formulary submission and approval later into August also reduces the time plan sponsors have to build, code and test the formulary prior to the January 1 effective date. This formulary build work starts in June and runs through the end of each calendar year. Further, this proposed change reduces the amount of time plan sponsors have to prepare the formulary display for October 1 and to prepare the formulary for print. Given the significant potential for operational disruptions, we urge CMS not to finalize the proposed changes to the summer formulary window.

Benefit Review (p. 198)

CMS proposes a maximum threshold of 25% generic composition for the non-preferred brand tier that sponsors may choose to offer for CY 2019. Sponsors that choose to offer a non-preferred drug tier will continue to have the flexibility to choose a cost-sharing structure that would be most appropriate for their benefit design. However, CMS notes that it intends to conduct outlier tests for sponsors who choose a co-pay structure for the non-preferred drug tier and expects such sponsors to demonstrate value to beneficiaries through a written justification that includes information about the generic drugs on the non-preferred drug tier.

Tufts Health Plan respectfully requests clarification on the rationale and process for conducting such outlier tests. Experience in our local and regional markets indicates that consumers prefer co-pays.



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Further, feedback from our members shows that our beneficiaries have a more favorable view of fixed co-pays than of co-insurance.

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

Sincerely,

A handwritten signature in black ink that reads "Kristin Lewis".

Kristin Lewis
Senior Vice President, Chief Public Affairs Officer
Tufts Health Plan