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

Re: SCAN Health Plan Comments on 2019 Advance Notice and Draft Call Letter
Docket Number: CMS-2017-0163

Dear Deputy Administrator Kouzoukas and Director Lazio:

SCAN Health Plan (SCAN) is pleased to submit the following comments in response to:

- *Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model*, issued on December 27, 2018, and
- *Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for MA Capitation Rates, Part C and Part D Payment Policies, and 2019 Draft Call Letter*, issued on February 1, 2018.

SCAN applauds the Administration for its leadership and direction in developing policies that will improve the health care of Medicare beneficiaries, including those who are low-income and have multiple chronic conditions. We appreciate the Centers for Medicare & Medicaid Services (CMS's) willingness to reach out to plans for ideas and recommendations over the past year, many of which were included in the 2019 Proposed Rule on Medicare Parts C and D and in the Advance Notice and Draft Call Letter.

We are also pleased with the passage of the *Balanced Budget Act (BBA) of 2018*, and, in particular, the provisions that make Special Needs Plans (SNPs) permanent, expand supplemental MA benefits, and increase the use of telehealth for MA enrollees. Combined, these developments will give beneficiaries exactly what they need for their particular conditions – a major advancement. Your commitment to making MA even better for beneficiaries is evident, and we thank you for your exceptional work in this area.

I. SCAN Health Plan

SCAN is a not-for-profit health plan that serves seniors through MA plans which include institutional, chronic care, and dual eligible special needs plans (SNPs). Approximately 194,000 Medicare beneficiaries are enrolled in SCAN's MA plans in California, making it the fifth largest not-for-profit Medicare Advantage Prescription Drug (MAPD) plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high quality care to the most vulnerable Medicare beneficiaries, including those who live with multiple chronic conditions, are eligible for nursing home care, and experience difficulty performing activities of daily living. Enrollees benefit from SCAN's partnerships with health care providers that engage with plan members to provide the right care at the right time, while maximizing beneficiaries' ability to maintain their independence. We are proud that SCAN MA plans received a 4.5 star rating for plan year 2018.

II. Summary of Key Provisions

SCAN is especially supportive of the following provisions:

- *Expanding Health Related Supplemental Benefits* – this proposal offers MA beneficiaries non-skilled benefits that will enable them to live independently in their homes, rather than be forced to move into institutions, and complements similar provisions adopted in the *BBA of 2018*.
- *Adding Mental Health, Substance Use Disorder, Chronic Kidney Disease, and other Conditions to the CMS-Hierarchical Condition Category (HCC) Risk Adjustment Model* – this proposal will allow plans to better serve beneficiaries with these conditions.
- *Increasing Flexibility in MA Uniformity Requirements* – this proposed interpretation is a major step forward in tailoring health coverage to individuals' needs; and
- *Improving Beneficiary Communications and Reducing Burden for Integrated Dual Eligible Special Needs Plans (D-SNPs*) – this proposal is important as we move toward the full integration goals envisioned in the *BBA of 2018*.

SCAN is concerned with aspects of a few proposals, in particular:

- *Implementing the New CMS-HCC Risk Model in 2019* – SCAN recommends delaying this model to 2020 to give MA plans more time to assess the impact of the significant changes proposed (e.g., ICD-9 to ICD-10 coding and full use of encounter data);
- *Increasing the Percentage of Encounter Data in Risk Score and Decreasing Encounter Data as a Diagnosis Source* – SCAN recommends also postponing this proposal to 2020 to ensure that CMS has validated the data before making a full transition;
- *Improving Drug Utilization Review (DUR) in Medicare Part* D – SCAN opposes instituting a formulary-hard edit at a dosage level of 90 MME/day with a 7-day supply allowance because it may have unintended negative consequences to beneficiaries.

III. SCAN Health Plan Comments on 2019 Advance Notice and Draft Call Letter

SCAN is pleased with the MA payment increase proposed by CMS for plan year 2019. This increase will enable plans to provide additional benefits and more specifically target the needs of Medicare beneficiaries.

Advance Notice (CY 2019)

End Stage Renal Disease (ESRD) Rates

- **CMS Proposal:** CMS proposes that, similar to the non-ESRD rate methodology, it will reprice the ESRD historical inpatient, hospital outpatient, and skilled nursing facility claims from 2012-2016 to reflect the most current (i.e., FY 2018) wage indices and re-tabulate physician claims with the most current (i.e., CY 2018) Geographic Practice Cost Indices. CMS is also proposing to reprice the ESRD prospective payment system dialysis claims for the years 2014-2016 and to adjust historical FFS claims for ESRD beneficiaries to account for legislative and regulatory changes to the provisions under section 1886(d)(5)(F) of the Act, and the establishment of 1886(r).
- **SCAN Comments/Rationale:** SCAN requests that CMS consider new IV therapy drugs in proposed payments rates. Due to the approval of new IV therapy, CMS has transitioned the calcimimetics drug class from Part D to Part B for Medicare FFS, including Sensipar and Parsabiv. We would like to confirm that the projected allowed drug costs minus the FFS Part B member cost-share have been factored into the 2019 MA Benchmark and ESRD Payment rates.

MA Employer Group Waiver Plans (EGWP)

- **CMS Proposal:** CMS intends to continue to waive the Bid Pricing Tool bidding requirements for all MA EGWPs for 2019. CMS is also considering alternative policies to pay EGWPs and is soliciting comment on these approaches.
- **SCAN Comments/Rationale:** SCAN supports CMS's proposal to fully phase-in individual-market plans' bid-to-benchmark ratios and the additional step to account for the difference between the proportions of beneficiaries in health maintenance organizations vs. preferred provider organizations between EGWP and individual-market plans. This will ensure fair and consistent payment across the MA program.

CMS-HCC Risk Adjustment Model for CY 2019

- **CMS Proposal:** CMS proposes several changes to the CMS-HCC Risk Adjustment Model. These include: 1) evaluating the addition of mental health, substance use disorder, chronic kidney disease, and other conditions to the model; 2) adjusting the number of conditions an individual beneficiary may have; 3) phasing-in the new model in 2019, starting with a blend of 75% of the risk adjustment model used for payment in 2017 and 2018 and 25% of the new proposed risk adjustment model; 4) updating the HCC-End Stage Renal Disease (ESRD) risk adjustment model; and 5) updating the Part D risk adjustment model (RxHCC) for 2019 to reflect the 2019 benefit structure.
- **SCAN Comments/Rationale:** SCAN supports adding mental health, substance use disorder, chronic kidney disease and other conditions to the CMS-HCC Risk Adjustment Model because it will allow plans to better serve beneficiaries with these conditions. However, because the changes to the model are significant, particularly when coupled with full encounter data, we recommend that CMS postpone the implementation of the new model to 2020. The data provided by CMS only incorporates ICD-9 codes and the new model will be using ICD-10 codes. Postponing the implementation by one year allows MA plans to study the new model with applicable ICD-10 data.

SCAN also supports CMS's direction in updating the ESRD HCC model for more recent data. However, the change to the proposed HCC-ESRD model appears to reduce the ESRD members' risk scores significantly. Given the complexity of the HCC-ESRD, CMS should be certain of the new model's accuracy before fully transitioning it. We recommend that CMS gradually phase-in the new ESRD HCC risk adjustment model over three years and consider using the new model only on the Encounter Data System portion.

MA Coding Pattern Adjustment

- **CMS Proposal:** CMS proposes reducing MA rates by the statutory 5.90% minimum to adjust for plans' coding practices relative to fee-for-service (FFS) Medicare. CMS is also considering alternative methodologies to calculate the coding pattern adjustment, referencing the methodologies included in the Advance Notice (2010 and 2016) and MedPAC's report to Congress (March 2017).
- **SCAN Comments/Rationale:** SCAN strongly recommends that CMS continue to use the current coding intensity method which involves estimations of relative differences in coding increases between FFS Medicare and MA populations. SCAN has concerns regarding coding volatilities and the other approaches suggested by CMS:

    - *Coding Volatilities.* Based on the actual risk adjustment factors (RAFs) shown on page 38 of the 2019 Advance Notice, FFS Medicare populations had substantial RAF coding volatilities between 2015 and 2017. The CMS has yet to provide a definitive analysis dissecting the root cause for the spike, even with the robust data it has on the FFS Medicare population. Therefore, we question whether sound estimation can be made to further isolate the true coding pattern differences between FFS Medicare and MA. In addition, MA plans have incentives to code more thoroughly than FFS providers who only need a minimum number for payment. As a result, some coding differences may be because MA plans are coding more accurately and completely than FFS.

    - *Other Approaches.* SCAN has several concerns with the suggested approaches CMS references, i.e., methodologies described in the 2010 and 2016 Advance Notices and a recommendation from a 2017 MedPAC report. For our 2010 Advance Notice comments, please review the endnote.[i] In the 2016 Advance Notice, CMS implies that the demographic score is the "gold standard." However, we believe that risk adjustment, based on beneficiary health conditions is a better and fairer method for MA payment. In the 2017 MedPAC report, the recommendation for adjusting for coding differences between MA and FFS is unclear.

Normalization Factors

- **CMS Proposal:** CMS proposes the 2019 normalization factor for Part C to be 1.041 for the CMS-HCC model for payment in 2017 and 2018, and 1.038 for the proposed "Payment Condition Count" model.
- **SCAN Comments/Rationale:** SCAN recommends that CMS account for changes to the normalization factor related to revisions to the International Classification of Diseases (ICD) over the last few years. Specifically, risk scores increased from 2015 to 2016 and, to some degree in 2017, partly due to the conversion of ICD-9 to ICD-10 codes in late 2015. Because this is a one-time system change (not a coding improvement), we believe that it should be factored out from the risk score trend, as it is not repeated

after 2017, or it should at least be reduced by using additional years of data to establish the risk score trend.

Encounter Data as a Diagnosis Source for 2019

- **CMS Proposal:** CMS proposes increasing the weight of encounter data in the risk scores from 15% to 25% and decreasing the weight on diagnosis data from 85% to 75%. CMS also proposes implementing the phase-in of the new risk adjustment model by calculating encounter data based on risk scores exclusively from the new risk adjustment model, while maintaining use of the current risk adjustment model for calculating risk scores with Risk Adjustment Processing System (RAPS) data.
- **SCAN Comments/Rationale:** SCAN requests that CMS postpone advancing the phase-in of the new risk adjustment model proposal for one year to ensure that the encounter data is validated and to provide plans with sufficient time to assess the impact of this change.

Draft Call Letter (CY 2019)

Enhancements to the 2019 Star Ratings and Future Measurement Concepts

New Measures for 2019 Star Ratings

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

- **CMS Proposal:** For the 2017 measurement year, CMS would expand its data sources for identifying all Part D enrollees with ESRD for exclusion from the measures to include ICD-10-CM codes found in both Part A & B claims and RAPS RxHCCs to use along with the Medicare Enrollment Database ESRD indicator that is currently used. CMS will add the SUPD measure, based on 2017 data, to the 2019 Star Ratings with a weight of 1 the first year and 3 in subsequent years.
- **SCAN Comments/Rationale:** SCAN supports using additional data sources to identify and exclude members with ESRD. This further ensures that the measure is applied to the people for which it is most clinically appropriate. We also support weighting this new measure as 1 for the 2019 Star Ratings. However, SCAN is not in favor of weighting the intermediate outcome measure a 3 in subsequent years because taking medication as prescribed is not an outcome, but a process.

Statin Therapy for Patients with Cardiovascular Disease (Part C)

- **CMS Proposal:** CMS proposes to include this measure in the 2019 Star Ratings as a process measure with a weight of 1 because it is based on a medical records review if medications were prescribed.
- **SCAN Comments/Rationale:** SCAN supports adding a new measure for statins for cardiovascular disease and weighting it as a 1 for the 2019 Star Ratings for Part C. In general, SCAN recommends that CMS lower the weighting of medication adherence measures because they are very specific and not about overall adherence. In addition, because this Part C measure (statins for cardiovascular disease) allows for the

exclusion of side effects such as myalgia, myositis, myopathy or rhabdomyolysis, we request that CMS also provide exclusions to statin measures in Part D.

Changes to Measures for 2019

Medication Adherence for Hypertension and Diabetes Medications (Part D)

- **CMS Proposal:** CMS proposes to increase the source data for capturing beneficiaries with ESRD to the following: ICD-10 codes found in Part A & B claims, RAPS, RxHCC, and the enrollment database ESRD indicator which is currently used.
- **SCAN Comments/Rationale:** SCAN supports using additional data sources to identify and exclude members with ESRD. This further ensures that the measure is applied towards those members for which it is most clinically appropriate.

Medication Adherence for Hypertension, Diabetes, and Cholesterol (Part D)

- **CMS Proposal:** CMS proposes to change the inpatient stay adjustments to the proportion of days (PDC) calculations for the calculation of adherence.
- **SCAN Comments/Rationale:** SCAN supports this proposal because the methodology aims to more accurately capture inpatient stay for the PDC calculation.

Temporary Removal of Measures from Star Ratings (Part C)

Reducing the Risk of Falls from the 2019 Star Ratings

- **CMS Proposal:** CMS proposes removing the Part C Measure, Reducing the Risk of Falling, from the 2019 Star Ratings. It will add a revised measure to the 2020 display page and include it in the Star Ratings for 2021.
- **SCAN Comments/Rationale**: SCAN supports a temporary removal of the falls measure but encourages CMS to continue its work in this area because falls is a major negative outcome for seniors.

Data Integrity

- **CMS Proposal:** CMS proposes to continue its data integrity reviews to identify incomplete or biased Star Ratings measure data. For 2019, the Part C Special Needs Plan Care Management and Part D Medication Therapy Management Program Completion Rate for a Comprehensive Medication Reviews measures, CMS proposes to define a contract as being non-compliant if it either receives a "No" or a 1, 2, or 3 on a 5-point Likert scale in the specific data element's data validation.
- **SCAN Comments/Rationale:** SCAN supports this proposal but encourages CMS to simplify or combine audits with similar data to ease administrative burden.

Proposed Scaled Reductions for Appeals Independent Review Entity (IRE) Data Completeness Issues

- **CMS Proposal:** CMS proposes a scaled reduction methodology that would be a three-stage process using the Timeliness Monitoring Project (TMP) data or audit for the means to determine: first, whether a contract may be subject to a potential reduction for the Part C or Part D appeals measures; second, as the basis for the determination of the estimated error rate; and finally, whether the estimated value is statistically greater than the cut points for the scaled reductions of 1, 2, 3, or 4 stars.
- **SCAN Comments/Rationale:** SCAN supports the concept of a scaled approach because the feedback from the TMP reviews and plan performance has been unclear. SCAN requests further information regarding if CMS plans to formalize and publish results of the TMP reviews and if plans will have an opportunity to rebut the results of a TMP audit before they are used for Star Ratings reductions.

Changes to Existing Display Measures

High Risk Medication (HRM) (Part D)

- **CMS Proposal:** This measure would remain on the display page for 2019 (based on 2017 data) and CMS proposes to adopt a specification change made by the Pharmacy Quality Alliance (PQA) to measure specifications for the numerator (beneficiaries with at least two fills of the same HRM drug on different dates of service) for the 2019 display measure.
- **SCAN Comments/Rationale:** SCAN supports keeping a display measure on HRM and specification changes, which makes the measure fairer by isolating beneficiaries with two unique fills.

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

- **CMS Proposal:** CMS proposes, for Measure 3: Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP): The proportion (XX out of 1,000) of individuals from the denominator receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies. CMS proposes to add only the OHDMP measure to the 2019 Part D display page (using 2017 data). All three measures will continue to be reported to Part D plan sponsors through the Patient Safety reports.
- **SCAN Comments/Rationale:** SCAN supports this proposal because it allow sponsors to monitor opioid overutilization across other plans and the performance of all contracts across the country.

Transition Monitoring (Part D)

- **CMS proposal:** CMS proposes to no longer display two separate contract-level measures, one for drugs within the classes for clinical concern and one for all other drugs. Instead, the results would be consolidated into one failure rate and display measure. This change aligns with the display measure for the Formulary Administration Analysis (FAA). Previously, the data was displayed as a percentage with one decimal place. In order to provide the most accurate results, beginning with the 2019 display measure, the data will be displayed as a percentage with two decimal places.

- **SCAN Comments/Rationale:** SCAN supports this proposal as it streamlines calculations for drugs within six classes of clinical concern (protected classes) as well as all other drugs.

Formulary Administration Analysis Measure (Part D)

- **CMS proposal:** This display measure, added in 2018, uses the results of the FAA used by CMS to evaluate whether Part D sponsors are appropriately adjudicating drug claims consistent with Part D requirements and sponsors' CMS-approved benefits. Previously, the data for this measure was displayed as a percentage with one decimal place. In order to provide the most accurate results, beginning with the 2019 display measure, the data will be displayed as a percentage with two decimal places.
- **SCAN Comments/Rationale:** SCAN supports this proposal as it streamlines calculations for drugs within six classes of clinical concern (protected classes) as well as all other drugs.

Potential Changes to Existing Measures

Plan All Cause Readmissions (Part C)

- **CMS Proposal:** CMS proposes adding observation stays to the numerator and denominator.
- **SCAN Comments/Rationale:** SCAN requests that CMS delay this proposal to make sure there is adequate time for alignment with other performance measures and to avoid disruption in beneficiaries' care. This is to ensure that the hospital and provider delivery systems have adequate time to implement robust care transitions practices for members receiving observation level of care.

Telehealth and Remote Access (Part C)

- **CMS Proposal**: CMS requests feedback on the feasibility of measures and strategies for addressing telehealth services, especially for measures related to Chronic Obstructive Pulmonary Disease, preventive/ambulatory care, high blood pressure, and diabetes care.
- **SCAN Comments/Rationale:** SCAN supports the use of telehealth-related measures, especially since they are targeting diabetes and ambulatory access. Greater access to telehealth enables providers to care for the frail population beyond the clinic or emergency department setting.

Medication Adherence for Cholesterol (Statins) (Part D)

- **CMS Proposal:** CMS proposes to apply the ESRD exclusion for the Statin Adherence Measure for the 2020 Star Ratings (based on 2018 data), in the same manner that the ESRD exclusion is currently applied to the Diabetes and Renin Angiotensin System Antagonists Adherence Measures.
- **SCAN Comments/Rationale:** SCAN supports this proposal, as it is a positive change that makes the measure more clinically appropriate. However, SCAN is concerned that CMS does not exclude Skilled Nursing Facility (SNF) stays from prescription drug coverage for MAPD Plans. This is can be disadvantageous to the members who are in SNFs and may be falsely positive around non-adherence. The SNF stays are not included in the adjustment for prescription drug plans.

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D)

- **CMS Proposal:** CMS proposes using the PQA updated measure for 2018 to include a new denominator and will apply this denominator exception to the 2020 Star Ratings.
- **SCAN Comment/Proposal:** SCAN supports this proposal because it is a fairer and more accurate account of CMRs completed. It excludes members who were enrolled in the plan for a short period but still gives them credit if they received a CMR within the 60-day period.

Potential New Measures for 2020 and Beyond

Transitions of Care (Part C)

- **CMS Proposal:** CMS requests feedback about a new Healthcare Effectiveness Data and Information Set Transitions of Care (HEDIS) measure.
- **SCAN Comments/Rationale:** SCAN does not support this measure because it would be very administratively burdensome for plans. In addition, the measures proposed are process measures and CMS currently uses outcomes measures for transitions of care (e.g., Plan All-Cause Readmissions).

Polypharmacy Measures (Part D)

- **CMS Proposal:** CMS proposes the use of PQA developed and endorsed measures that identify potentially harmful concurrent drug use or polypharmacy: 1) Polypharmacy: Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH); 2) Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS); 3) Concurrent Use of Opioids and Benzodiazepines. All three measures will be added to Display Page for 2021 (2019 data), and will be considered for Star Ratings for 2023 (2021 data).
- **SCAN Comments/Rationale:** SCAN does not support adding these three measures to the Display Page with future considerations for Star Ratings because the Concurrent Use of Opioids and Benzodiazepines measure is already addressed and monitored through the Overutilization Monitoring System (OMS). Additionally, there is overlap of members counted in the measure for both Concurrent Use of Opioids and Benzodiazepines and Poly-CNS**.**

Additional Star Ratings Recommendations

- SCAN also provided several recommendations on Star Ratings in its comment letter on the Proposed Rule on Medicare Parts C and D, submitted to CMS on January 16, 2018. Please refer to this letter for further suggestions on the impact of measures on older beneficiaries, threshold determination, transparency, high performing plan rewards, socio-economic factors, and physician experience surveys.

Audit Process Changes

- **CMS Proposal:** CMS proposes several changes to the audit process, including 1) excluding the Compliance Program Effectiveness (CPE) conditions in determining whether a threshold for a validation audit (more than five audit conditions) has been met; 2) allowing the same independent auditing firm that they used for their annual external CPE audit if the firm has not provided consulting services or assistance with the correction of audit findings; 3) creating a validation audit work plan template that organizations would begin using in 2019; 4) extending the current timeframe by 30 days so organizations would have 180 (instead of 150) days from the date CMS accepts their program audit correction action plans; 5) requiring a plan to copy its independent auditing firm when submitting its validation audit report to CMS; and 6) allowing plans that have recently undergone a program audit to not be required to complete an independent CPE audit for one-year from the date of the program audit.
- **SCAN Comments/Rationale:** SCAN supports the proposed changes noted above and believes these are reasonable changes for the industry.

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

- **CMS Proposal:** CMS proposes to add an icon to plans in Medicare Plan Finder that indicates receipt of a CMP. The intent is to provide additional information to help Medicare beneficiaries make informed enrollment choices.
- **SCAN Comments/Rationale:** While SCAN supports CMS's commitment to be more transparent and to provide Medicare beneficiaries with more relevant information, we recommend that CMS delay implementing this change and continue to work with Medicare plans, stakeholders, and advocates to refine this idea. A delay will also provide time for the industry to consider the potential implications of this change.

Health Related Supplemental Benefits

- **CMS Proposal:** CMS proposed to expand the scope of primary health related supplemental benefit standard in the 2019 Draft Call Letter. Since then, Congress passed the BBA in February 2018, which includes a provision (Section 50322) that adopts (beginning 2020) the inclusion of non-medical services in supplementary benefits for chronically ill Medicare Advantage enrollees. Examples of benefits include acupuncture or alternative therapies, counseling services, and enhanced disease management.
- **SCAN Comments/Rationale:** SCAN applauds CMS and Congress for promoting policies that expand non-medical benefits for MA enrollees. We feel that the ability to offer these newly covered, non-skilled benefits will enable individuals to remain independent and live in the community, which is better for the beneficiary and the Medicare program.

Enhanced Disease Management (EDM) for D-SNPs and Institutional Special Needs Plans (I-SNPs)

- **CMS Proposal:** In an effort to improve care coordination and enhance the experience of care for beneficiaries, particularly those in SNPs, CMS is including an EDM benefit as a proposed supplemental

benefit in MA plans' bids and submitted plan benefit package. The EDM supplemental benefit will not be made available to C-SNPs because they already include targeted disease management elements (beyond the EDM supplemental benefit requirements).

- **SCAN Comments/Rationale:** SCAN generally supports this proposal and currently offers these components of disease management to plan beneficiaries.

MA Uniformity Flexibility

- **CMS Proposal:** CMS has determined that plans can provide certain enrollees with access to different benefits and services. Specifically, MA plans can offer targeted cost sharing and supplemental benefits for specific enrollee populations based on health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly.
- **SCAN Comments/Rationale:** SCAN strongly supports CMS's proposal to provide flexibility in offering medical and supplemental benefits for members who meet specific medical criteria. For further information, please refer to SCAN's comment letter on the Proposed Rule for Medicare Parts C and D, submitted to CMS on January 16, 2018.

SNP-Specific Networks Research and Development

- **CMS Proposal:** In the CY 2018 Final Call Letter, CMS announced plans to move forward on developing SNP-specific network adequacy evaluations.
- **SCAN Comments/Rationale:** SCAN appreciates CMS's interest in ensuring SNP populations have sufficient access to the most appropriate providers. However, we are concerned that it might add a layer of complexity in certain states that already establish separate applicable and SNP network adequacy standards beyond what CMS currently requires. For additional comments, please refer to SCAN's comment letter on the Proposed Rule on Medicare Parts C and D Proposed Rules, submitted to CMS on January 16, 2018.

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

- **CMS Proposal:** The Advance Notice clarifies that MA plans could use reward incentives to encourage beneficiaries to complete an HRA.
- **SCAN Comments/Rationale:** SCAN is generally supportive of providing reward incentives to encourage beneficiaries to complete an HRA, although plans will need to consider the cost. For example, to target members that have habitually declined to participate and/or unwilling to call back after many attempts, we recommend the ability to target the portion of the SNP population for incentives that have not had an HRA for two years in a row, rather than the entire population (or similar criteria based on history of participation). Otherwise, the cost may be prohibitive for plans with large populations.

Additional PQA Medication Adherence Measures (Part D)

- **CMS Proposal:** CMS proposes *not* including two additional PQA endorsed medication adherence measures and not considering adding these adherence measures to the Patient Safety reports, the Display Page, or Star Ratings at this time. They include: 1) Adherence to Non-Warfarin Oral Anticoagulants (ADH-NWOA) and Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (ADH-MS). CMS is considering including these measures within the quarterly outlier reports through Patient Safety Analysis.
- **SCAN Comments/Rationale:** SCAN supports not including these three measures in the Display or Star Ratings at this time, but we do support having them included in quarterly outlier reports.

Improving Beneficiary Communications and Reducing Burden for Integrated Dual Eligible SNPs (D-SNPs)

- **CMS Proposal:** CMS proposes reducing administrative, existing statutory, regulatory, and operational constraints related to aligning integrated D-SNPs.
- **SCAN Comments/Rationale:** SCAN strongly supports the proposals presented by CMS to better integrate D-SNP products available to dually eligible beneficiaries. This would be done by CMS working more closely with individual states to align and integrate the Medicare and Medicaid coverage segments for dual eligible beneficiaries. Specifically, SCAN supports CMS collaborating with states in performing oversight of integrated D-SNP plans; developing integrated beneficiary information model materials such as summary of benefits, Annual Notice of Change/Evidence of Coverage, provider and pharmacy directories, and formularies; creating integrated D-SNP non-renewal notices; and developing a more robust D-SNP model of care that better describes and integrates Medicare and Medicaid managed long term services and supports.

  In addition, SCAN appreciates CMS's invitation to States to identify opportunities to promote improved integration of Medicare and Medicaid services through integrated D-SNPs and an overall better experience by people who are dual eligible beneficiaries. We are very encouraged by this commitment from CMS, and the desire to partner with state Medicaid agencies to optimize the integrated D-SNP model.

CY 2019 Formulary Submission Window/CY 2019 Formulary Reference File

- **CMS Proposal:** CMS proposes to remove drugs from CMS FRF for which utilization under Part D would be extremely rare to prevent beneficiary confusion since these drugs are displayed within the Medicare Plan Finder, but are more commonly covered under Medicare Part B. CMS also intends to move the July Limited Formulary update window later into the summer, with the goal being the inclusion of newly approved brands and generics that occur in July and into August. Also, in an effort to provide more up-to-date information within the MPF, CMS intends to add an enhancement-only window that will occur in late fall. Likewise, CMS also intends to add a January 2019 formulary update window.
- **SCAN Comments/Rationale:** SCAN supports the proposal of removing medications that are most commonly prescribed under Medicare Part B from CMS FRF to prevent the prescriber and member confusion. However, SCAN respectfully requests keeping the Summer Formulary submission window in July to ensure meeting the printing marketing materials deadlines in preparation for the open enrollment,

as well as coding and testing formularies. SCAN also respectfully requests keeping the current annual and monthly formulary submission period as is because the proposed additional formulary submission windows will coincide with substantial plan activities and deliverables related to the open enrollment period and plan benefit set up and testing in preparation for January 1st.

Tier Composition

- **CMS Proposal:** Based on an analysis of CY 2018 formulary and benefits data, CMS proposes a maximum threshold of 25% generic composition for the non-preferred brand tier for CY 2019.
- **SCAN Comments/Rationale:** SCAN supports CMS's proposal of having a maximum 25% generic composition apply to the non-preferred brand tier. In addition, a maximum 50% generic composition threshold for the non-preferred drug tier should remain as is. The proposed tier composition encourages more transparency and prevents member confusion.

Improving Drug Utilization Review Controls in Medicare Part D

- **CMS Proposal:** CMS proposes five new strategies to more effectively address the national opioid epidemic in Part D among beneficiaries who may not be addressed through the OMS -- over 90 Morphine Milligram Equivalent (MME) per prescriber/pharmacy as well as opioid-naïve patients. The proposals include (1) enhancing OMS by adding additional flags with potentiator drugs (gabapentin/pregabalin) to concurrent Benzodiazepine use; (2) implementing revisions to PQA opioid quality measures with a new PQA measure (Concurrent Use of Opioids and Benzodiazepines); (3) expecting all sponsors to implement hard formulary-level cumulative opioid safety edits at point of sale (POS) at the pharmacy at a dosage level of 90 MME/day with 7-day supply allowance (which can only be overridden by the sponsor); (4) implementing 7-day supply limit for initial fills of opioids prescriptions regardless of daily dose maximum; and (5) expecting all sponsors to implement soft POS safety edits on duplicative therapy of multiple long-acting opioids and requesting feedback on concurrent prescription opioid/benzodiazepine soft edits.
- **SCAN Comments/Rationale:** Below are SCAN's comments to the above proposals:

  (1) *Additional Flags.* SCAN supports adding additional flags for potentiator drugs used in combination with opioids in OMS, as this informs the sponsor of any increased risk of adverse events in its concurrent use or indication of members switching to alternative pain treatments.

  (2) *New PQA Measure*. SCAN also supports adding a new PQA measure, Concurrent Use of Opioids and Benzodiazepines, to Patient Safety Reporting to help plans monitor rate as well as compare against national averages.

  (3) *Soft/Hard Edits.* SCAN requests keeping existing options of setting soft cumulative opioid claim edit MME threshold at or above 90 mg per day and/or any hard cumulative opioid claim edit at or above 200 mg per day and including multiple prescriber or multiple pharmacy criteria in these edits for 2019.

Instituting hard edits is an effective means to limit an excessive supply of opioids; however, we recognize that an edit at 90 MME may have the unintended consequence for opioid dependent beneficiaries to seek illicit substances, e.g. heroin. We support CMS's efforts to prevent prescription opioid overuse, and recommend re-educating providers rather than instituting a formulary hard edit and 7-day supply allowance because:

- Instituting this more restrictive hard-edit of 90 MME/day while eliminating the option of including multiple prescribers/pharmacies in the edit will significantly increase the number of coverage determinations requests that CMS generally expects to be resolved within 24 hours of receipt of the prescriber's supporting statement;

- Providing a 7-day transition supply for the single opioid accompanied by a transition letter notification may not be clinically appropriate for a member who may require a short-acting (SA) and a long-acting (LA) opioid and may coincide with the regular transition period for a member (e.g., a new member enrolled to a plan who is eligible to get a 30-day transition supply/transition notification of a non-formulary opioid) causing member and prescriber confusion.

  A hard edit also will lead to member dissatisfaction with the pharmacy and insurer, who from the beneficiary's standpoint is not providing medication as prescribed by their physician. If all sponsors were to implement hard formulary-level cumulative opioid safety edits at POS at the pharmacy at a dosage level of 90 MME/day with a 7-day supply allowance (which can only be overridden by the sponsor), it would not only create a significant administrative plan burden but, more importantly, may impede access to medically necessary drug regimens for our members.

(4) Targeted Population Approach. While SCAN supports efforts for preventing prescription opioid overuse, implementing a targeted population approach will avoid administrative burden on the health system while achieving the same outcome. Additionally, while we support the ability to limit opioid naive patients to a 7-day supply, it may not be feasible to establish this edit in patients with acute pain since acute-versus-chronic pain diagnosis is not available on the prescription. In addition, we do not have the claims history for members who are new to the plan and may not be able to determine if this is a new therapy or an ongoing therapy. This may limit a new member's access to a necessary drug.

(5) Short/Long Acting Therapy. SCAN supports implementing a soft POS edit for duplicative LA opioid therapy and agrees to not implement a duplicate SA acting opioid POS edit for now until operational experience is gained on the LA opioid edit.

Using the Best Available Information When Making Part B Vs. Part D Coverage Determinations for Immunosuppressants and Inhalation Durable Medical Equipment Supply Drugs

- **CMS Proposal:** CMS proposes new guidance on how Part D sponsors should determine whether a drug is a Part B drug and when to revise its findings if the information from CMS changes.
- **SCAN Comments/Rationale:** SCAN supports new guidance because it will streamline/simplify the coverage determination process and establish CMS as the single source for transplant information leading to the accurate Part B versus Part D decisions. SCAN requests responses to the following questions:

- Because some plan sponsors may have a Pharmacy Benefit Manager (PBM) delegated to process Coverage Determinations, will CMS allow for a PBM to gain access to the MAPD System to look up transplant information when processing Coverage Determinations for a beneficiary?
- Can CMS provide plan sponsors the "Medicare Part A Fee-For-Service" report/data that includes transplant information related to Heart, Liver, Lung, etc. for plan sponsors to determine Part B vs. Part D?
- Can CMS clarify the information needed regarding what notification requirements must be made to a beneficiary when the plan subsequently changes coverage for an immunosuppressant from Part D to Part B coverage due to Best Available Evidence?

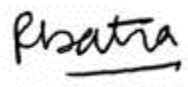
Part D Mail-Order Refill Consent Policy – Solicitation for Comments

- **CMS Proposal:** CMS requests any information and data associated with mail-order auto-ship programs (other than those detailing on-time refills, medication possession ratio, or proportion of days covered) that indicate actual improved adherence by patients resulting from automatic (not patient-initiated) refills.
- **SCAN Comments/Rationale:** SCAN supports eliminating affirmative prior consent for refills while expecting plans to implement a full refund policy for any refills auto shipped that a beneficiary reports or returns as unneeded or otherwise unwanted.

Conclusion

We appreciate your consideration of these comments and recommendations and look forward to our continued work with the agency on these important issues. Please do not hesitate to reach out to me at any time if I can provide additional information.

Sincerely,



Romilla Batra, MD
Chief Medical Officer
SCAN Health Plan

Endnotes

[i] Section D. Adjustment for MA Coding Pattern Differences – SCAN Comments to 2010 Advance Notice, Section on Coding Pattern Differences

Results of Coding Pattern Difference Analysis

We recognize the effort that the CMS has put forward on the subject of MA Coding Pattern Difference Adjustment. And we understand and agree that the premise of the coding pattern difference adjustment is to adjust for the difference in coding patterns between Original Medicare and Medicare Advantage providers. However, we believe there are three areas that require additional attention prior to any implementation of coding pattern difference adjustment. They are:

1. Need for a "Gold Standard".

In order to effectively measure the difference in coding pattern between the two programs, we believe a gold standard is required. That gold standard would be found by:

1. Conducting a complete medical record review to estimate the "medical record risk score" ("MRRS") for sample from two populations: Original Medicare ($MRRS_{OM}$)and Medicare Advantage ($MRRS_{MA}$).
2. Comparing the MRRS to its respective actual risk score (RS_{OM} and RS_{MA}) to determine the coding intensity (CI_{OM} and CI_{MA}).
3. The difference between CI_{OM} and CI_{MA} then becomes the Gold Standard.

It is our belief that this Gold Standard would be a more reliable estimate of the coding pattern differences between Original Medicare and Medicare Advantage and could be applied uniformly among all plans.

2. Recognition How Market Differences Impact Documentation and Coding Improvement Over Time.

We find the current study does not sufficiently address the effect of documentation and coding improvement and completeness of risk adjustment encounter data. This limitation results in the potential for overestimating the difference in coding pattern between Original Medicare and Medicare Advantage.

One of the primary reasons some MA Plans have risk scores that increased faster than Original Medicare is because of the market dynamics of capitation. In the Southern California market in particular, there is a 20-year history of provider payment based on capitation. This had the effect of suppressing the need for robust coding and documentation.

With the introduction of risk adjustment and its attenuate need for very robust coding and documentation, it follows and is shown that providers under capitation arrangement not only had to change individual behavior, they needed significant infrastructure investment to submit encounter data. This double impact means that these markets are behind those where capitation is not the predominant method of payment by Medicare Advantage Plans. Therefore, we can reasonably assert that the year of year increases are not anomalies; it is a natural result of a market processing a major change. Therefore, to in essence, penalize plans for implementing what is the right thing to do – pay based on member risk – at this point in time is counterintuitive and destabilizing to beneficiaries (see comments following).

3. Disease Score Variation Estimate

We believe that one of the reasons for variation in disease score changes among contracts is the different characteristics, such as geographic area and severity of membership, among contracts. We recommend that CMS use a "case-control matching" method to estimate the difference in risk score change between each Medicare Advantage contract and Original Medicare.

4. Distribution of Baseline Disease Score

We believe that one potential reason for disease score growth slightly faster among Medicare Advantage Plans is the baseline disease score. We recommend that CMS examine the distribution of baseline disease score particularly zero disease score and high disease score and adjust for the difference in the analysis.

Calculation of The 2010 Coding Pattern Difference Adjustment Factor

1. Definitions of Stayers

The definitions of stayers in the cohort analysis and in operationalizing coding intensity adjustment are different. In the cohort analysis, stayers are defined as beneficiaries who were in a Part C plan in the July of each cohort year, as well as in each respective data collection year. Therefore, stayers were enrolled with the Part C plan for at least 30 months. However, stayers are defined as beneficiaries who enrolled in Part C plan in January 2009. Therefore, the minimum number of months stayers enrolled with the Part C plan is 13 months.
We recommend that CMS apply the stayer definition in cohort analysis when calculating plan's stayer percentage.

2. Operationalize MA coding pattern difference factor

We recommend that CMS to apply coding intensity adjustment to all health plans and all members if CMS decide to implement it. As previously commented, applying adjustment for MA coding pattern difference at contract level will create network instability for geographical areas with a heavy penetration of percent of premium capitation arrangements with providers.

3. Collection of Encounter Data from Part C plans

In principle, we support the idea of collecting encounter data from Part C plans. However, we recommend that CMS to consider piloting the collection of full encounter data prior to implement it across all health plans. In the geographical areas with a heavy penetration of capitation arrangement with providers, capitated entities (e.g., medical groups) may not have the infrastructure to capture all data elements required. In order for CMS to get accurate and complete encounter data, these providers need to upgrade their infrastructure to meet the needs. In light of potential revenue reduction (compared to medical cost inflation), it can be a burden on the providers and may take some time for them to achieve the level it needed.