Independence’s comments to CMS’ proposed 2019 Part C & D Regulation are listed below. Thank you for your time and consideration.

**COMMENTS:**

**Star Ratings**

**Weighting of Star Ratings Measures**

* Issue: Inclusion and weighting of patient-reported measures**.**
  + **IBC opposes CMS’s proposed change to make patient experience measures become triple weighted.** If anything, the patient experience measures should be moved to a weight of 1 instead of 1.5. Relatedly, no survey measures should be triple weighted, as scores can be skewed depending on the sample. IBC proposes reduction of the HOS triple weighted measures and recommends no patient reported measure be higher than a 1.5 weight. Patient reported data is not as reliable as claims, PDE, or chart data.
* Issue: Access measures should not be triple weighted.
  + **IBC is in favor of keeping access measures at a weight of 1.5.**
* Issue: On the AHIP call, one pan proposed membership weighted clustering for determining cut point thresholds.
  + **IBC opposes this. It would give an unfair advantage to larger national plans who want to blame their poor performance on their membership sizes.**

**Contract Consolidation Policy**

* Issue: Rules around weighted Star Ratings for contracts that consolidate
  + **IBC fully supports CMS’s proposed policy on contract consolidation – national contracts have had an unfair advantage of being able to consolidate their products to create the illusion of higher Star ratings.** 
    - Unfair bonus implications
    - Star rating and payment need to be reflective of membership at the time of the rating.

**Changes to Part C Measures - BAPP**

* Issue: The Beneficiary Access and Performance Problems is being changed.
  + **IBC agrees that the new version of the Beneficiary Access measure should stay on display for the two full years, per updated guidance, before being added to the Star Ratings. The old Beneficiary Access measure should remain in Star Ratings until the new one can come off display.**

**Exemption for Plans Affected by Hurricanes**

* Issue: Plans affected by wildfires, hurricanes, and other natural disasters will not be required to have a CAHPS survey or a HOS survey.
  + **IBC would like more information on how the quality bonus payments will be calculated fairly with plans excluded from the measurements.**

**Categorical Adjustment Index**

* **IBC would propose changing the CAI Calculation to hold harmless plans with Limited LIS/dual populations.**

**Addition of New Measures That Evaluate Quality Based on New Technologies**

* Issue: Use of telemedicine to help close quality gaps.
  + **IBC is generally supportive of using telemedicine for this purpose but requests more information about how it would be operationalized.**

**Regionally Adjusted Rates**

* Issue: IBC requests more information on the methodology behind how the rates would be regionally adjusted, but we are open to the idea.

**Data Integrity**

* Issue: Scaled reductions for IRE measures
  + **IBC supports scaled reductions for all data related measures; reductions should be related to volume of appeals as opposed to size of the plan.**
  + We also propose that if an identified data issue did not harm members, plans should be able to resubmit with limited penalty (not dropped to 1 Star).

**Process for Est. Cut Points**

* Issue: Rolling three year trending cut points given in advance of the measurement year
  + **IBC supports publishing cut points prior to the measurement year; we are also supportive of a three year trend to project measure cut points.**

**Plan Preview 2**

* **IBC suggests releasing national data during the second plan preview. This will help with data validation efforts as comparison across industries data will help identify trends.**

**Changes to Notification Requirements**

* IBC supports the elimination of MA Plan notice for cases sent to IRE.

**Moving Star Ratings Measures**

* IBC supports moving measures to display if they have “substantial changes” to their calculations.

**Part D Stars Issues**

* Obtain data from drug assistance programs – **IBC suggests CMS make PDEs available for members in drug assistance programs.**
  + Alternatively, we suggest members enrolled in drug assistance program be excluded from measures that require compliance through drug therapies.
* Exclusions for trial periods for Part D medication
  + **IBC suggests implementing exclusions for members who are in trial periods for Part D medications.**

**Changes to Specific Measures**

* Issue: Cut points topping out (BMI and CDC-N)
  + **Due to the high 5-star threshold, we recommend removing the measures BMI and CDC-N, which are “topped out”.**
* OMW/ART Measures
  + **There should be different exclusions because sometimes treatments for compliance are not medically appropriate, e.g., DMARD.**
* ART Measure
  + **Evidence of treatment for rheumatoid arthritis not limited to DMARD should be considered for compliance.**

**Improvement Measures**

* IBC suggests holding 4-star plans harmless with improvement measures, similar to R-Factors.

**MA Issues**

We ask that CMS provide clarification on:

**Flexibility in MA Uniformity Requirements**

* Can we clarify If the plan level deductible could be eliminated (or $0), vs. just reduced?
* Can we clarify if “lower the cost-sharing” means a $0 copay? In the past CMS considered that waiving the copay and it was not allowed. Specific ranges would be appreciated.
* Is their flexibility to permit this reduced benefit cost-sharing to a subset of network providers as long as all members with the specificed medical conditions receive the same lower cost for using these providers vs. the entire provider network?

**Segment Benefits Flexibility**

* Could this segmentation be considered offered to a sub-set of the network providers? Plans are trying to enter into risk arrangements or incentive arrangements for providers that are willing to spend time with our members to help manage their conditions. Plans want to be able to drive members to these provider partners through medical benefits and supplemental benefits. Being able to offer lower cost-sharing to support these arrangements would benefit the members and assist with maintaining costs to the Medicare program.

**Meaningful Difference in MA Bid Submission and Bid Review**

* We thank CMS for this change. If CMS does establish any limits to the number of plans offered, we would ask them to treat full-provider networks separately from more limited network provider network plans.
* Also, if number of plan limits (offered by each MAO) are imposed, it should be at the parent owner level vs. marketing name level. We have a national plan who is able to offer multiple plans as Company A and multiple plans as Company B. It is several years post-merger and this creates an unfair advantage in the marketplace on the number of offerings.

**Reducing Provider Burden**

* Suggest that plans should be able to hold provider payment if they don’t respond to requests to update/verify info for the Provider Directory. (This is already done on the FFS side.)

**Seamless Conversion**

* Support reinstituting seamless conversion for commercial members to MA when they become eligible. This is preferable to an opt-in option even if they make some stipulations/requirements like needing to have a certain Star Rating, etc.

**Part C Preclusion List**

* Will the proposed preclusion list eliminate the requirement to review the regional Medicare Opt-Out lists for practitioners?
* Will the proposed preclusion list include the entire country (the current listings are regional)? Please confirm whether it will be updated monthly.
* Will the proposed list be able to be downloaded/exported?
* Will each provider be identified by a valid NPI?

**Marketing (Compliance Policies)**

* Based on the proposed revisions, we assume that those materials considered “communication” materials do not need to be submitted in HPMS. Is that correct?
* We also request further clarification on what is defined as “communication” materials (with specific examples), and whether this will be further defined/explained in sub-regulatory guidance.
* Clarification is needed regarding allowable marketing during the Open Enrollment Period (OEP). We do not suggest limiting marketing entirely during the OEP. One suggestion is to limit marketing that specifically references the OEP during this timeframe.

**Part D Issues**

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| --- | --- |
| **CMS Proposal** | **IBC Comments** |
| Overview: Part D Drug Management Programs | IBC would like for CMS to take a firm position on the opioid epidemic and to define very clear direction to health plans.  We would also like for CMS to adopt the CDC opioid guidelines as the basis for MED thresholds to ensure consistency. |
| Definitions: Potential At-risk beneficiary, At-risk beneficiary, frequently abused drug, clinical guidelines, program size, exempted beneficiary (§423.100) | We don’t agree that residents of long-term care facilities should automatically be considered exempted beneficiaries. |
| Special Requirement to Limit Access to Coverage of Frequently Abused Drugs to Selected Providers (§423.153(f)(4)) | We recommend considering a shorter period between beneficiary identification and lock-in, as 6 months puts the beneficiary at a much higher risk of opioid-related adverse effect or incident. |
| Part D Tiering Exceptions | We recommend adding more clarification to “alternative drugs on lower cost-sharing tier” because drugs have overlapping indications and are not always appropriate to interchange based on this language.  We recommend stating that a tier exception be granted when formulary alternatives within the same class exist on lower tiers and have the same medically accepted indication as the requested drug. |
| Request for Information Regarding the Application of Manufacturer Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale (POS) | We recommend against this approach for several reasons:   1. Operationally prone to inaccuracies because we do not know the rebate values or collect for 180 days 2. Will lead to Medicare Plan Finder (MPF) inaccuracies and will have negative impact on STARS 3. Poses a financial risk because the POS calculation may not align to actual rebates received after our plan’s 180-day period. Plan runs risk of losing money or being too conservative at POS. 4. NCPDP does not accommodate this sort of arrangement 5. Plans will lose the ability to negotiate rebates when this information becomes so public |