March 5, 2018

Seema Verma

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-4182-P

PO Box 8013

Baltimore, MD 21244-8013

Submitted electronically via <https://www.regulations.gov>

**RE: CMS-2017-0163 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**

Dear Ms. Verma,

We appreciate this opportunity to offer comments on the 2019 advance notice and 2019 draft call letter.

Priority Health is a Michigan-based non-profit health plan nationally recognized for improving the health and lives of its members. Created nearly 30 years ago, we offer a broad portfolio of health benefit options for Medicare, Medicaid, employer group and individual plans. Currently we have more than 130,000 members in our Medicare Advantage plans in our 68-county service area in Michigan**.**

We respectfully submit the comments below. The comments we are submitting are being presented in the order that they appear in the advance notice and draft call letter.

**Potential Changes to Existing Measures:**

1. Medicare Advantage Coding Pattern Adjustment (page 35)

We are satisfied with the application of the statutory minimum and suggest we maintain the current methodology.

1. **Beneficiary Access and Performance Problems (BAPP) (Part C & D) (page 112)**

We support the temporary removal of the BAPP measure. We propose CMS to maintain the revised measure on the display page for two years to ensure the application and utility of this measure meets the intent it was designed for

1. **Telehealth and Remote Access Technologies (Part C) (page 146)**

We are sharing our feedback on the appropriateness of including telehealth and/or remote access technology encounters. We believe that engaging beneficiaries in a telehealth or remote access technology setting is feasible. This is a significant stride in providing more options to the beneficiary receiving needed care. Addressing barriers related to access is of most concern for health plans. We are supportive that this type of visit can be just as effective as an in-person visit. *(Our support of such services has been reflected in our letters to CMS dated April 24, 2017 and November 20, 2017.)*

CMS welcomes feedback to share with NCQA on feasibility of and strategies for addressing telehealth services as it relates to spirometry testing in the assessment and diagnosis of COPD, adults’ access to preventative/ambulatory health services, controlling high blood pressure, and comprehensive diabetes care.

We believe that allowing remote access technology encounters to be counted as eligible encounters will allow health plans to have greater flexibility and innovation to address barriers to care. These video visits would be reasonable replacement encounters.

1. **Cross-Cutting Exclusions for Advanced Illness (Part C) (page 146)**

We support the assessment to exclude patients in advanced stages of chronic illness for selected HEDIS measures. Patients who are on the trajectory of decline often have needs that are related to management of their symptoms and the focus is more often on palliative/comfort care. Exclusions would allow for patient centered treatment plans that focus on ensuring the complex needs of these patients stay at the center of the care plan.

1. **Health Related Supplemental Benefits (page 182)**

We support CMS in addressing the importance of daily maintenance for the Medicare beneficiary. It will be invaluable to understand the criteria that will aid in implementing this benefit. While we are passionate about the opportunity to make this available CY2019, in order for us to develop a program with financials considered, we are proposing to delay the CY 2019 implementation and consider this for CY2020. Another key aspect will be understanding how to best inform the beneficiary of such services. Today beneficiaries are able to do plan to plan comparisons with similar benefits. Going outside of the scope and allowing creativity is a differentiator that we would want to make sure the beneficiary comprehends when making a choice between health plans.

Under the proposed new CMS interpretation and expanded scope of the health related supplemental benefit standard, the new broader interpretation states that the item or service must be medically appropriate and be ordered by a licensed provider as part of a care plan if not directly provided by one. The work and scope of practice for licensed care managers includes the formulation of an interdisciplinary plan of care in collaboration with the care team.

Therefore we ask that CMS take this into account in defining licensed provider, and that this definition will include qualified case managers. This would also coincide with the enhanced disease management benefit.

1. **Medicare Diabetes Prevention Program (MDPP) Services Clarification (page 185)**

We support CMS in the decision to make MDPP a covered preventive service. It is mentioned that MA plans may also offer additional MDPP-like services as a supplemental benefit. We are seeking clarification on the ability to offer similar supplemental benefits which service conditions for behavioral health conditions and/or chronic disease using virtual care solutions. This promotes timely access to needed care which supports stabilization and prevents unplanned or emergent utilization.

1. **Enhancing the OMS by adding additional flags for high risk beneficiaries who use “potentiator” drugs (such as gabapentin and pregabalin) in combination with prescription opioids. OMS already flags concurrent benzodiazepine use. (page 204)**

This largely has little effect on the plan’s work, unless the plan was to complete the work in house and not use a first tier entity. Forecasting the future, if this remains a topic of interest, or utilization remains high, it is not entirely unlikely that CMS would make this into a quality measure similar to the below bullet point.

If CMS pursues further management/restriction on gabapentin/Lyrica it could lead to a significant amount of work considering the drugs are used for multiple indications

1. **Implementing revisions to the PQA opioid quality measures used by CMS, and consideration of a new PQA measure, Concurrent Use of Opioids and Benzodiazepines. [See the Enhancements to the 2019 Star Ratings and Future Measurement Concepts section of the draft 2019 Call Letter] (page 204)**

If the prescriber deems the combination to “medically necessary” the plan has little latitude to effect a change in prescribing. This would not achieve CMS’ goal to reduce the use of opioids. We encourage CMS to consider how a plan and provider could partner better to achieve the desired impact.

1. **Expecting all sponsors to implement hard formulary-level cumulative opioid safety edits at point-of-sale (POS) at the pharmacy (which can only be overridden by the sponsor) at a dosage level of 90 MME per day, with a 7 days supply allowance. (page 204)**

Currently, CMS has prescribed a floor for the hard-stop MED edit at 200 MED/day. Reducing the threshold would result in an additional three times as many members being. This is likely a conservative estimate considering that the MED would only need to exceed 90 for a single day to trigger the edit.

Additionally, CMS is proposing that those who exceed 90 MED/day and receive a POS rejection be allowed a 7 day supply as a sort of “transition fill”. The caveat here is that members would only be allowed one prescription for the 7 day fill. This means that if someone presented with a prescription for a long-acting and a short-acting opioid, the member in coordination with the dispensing pharmacist would have to evaluate which of the two drugs to fill – they could not have both. There is also no clarification on how often this would “reset” – Monthly? Quarterly? Annually? This creates issues for withdrawal as well as potential liability for the dispensing pharmacist.

The current 200 MED limit has driven opioid utilization down. However, it has also caused a significant amount of administrative burden on plans and providers as well as caused largely unnecessary delays to beneficiaries receiving their medication(s). CMS notes, again, in the draft Call Letter that plans should only require provider attestation that a dose > 90 MED is needed before approving the request. It seems onerous and unnecessary to have the prescriber, who wrote the prescription, attest to the medical necessity of that same prescription through a separate process.

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| Pt presents with Rx | → | Claim rejects for exceeding 90 MED/day | → | Pt is given 7-day supply and told to seek PA | → | Plan receives PA request | → | PA request notes member "need this dosage" | → | Plan approves request | → | Plan notifies provider/member | → | Member able to fill 30 day rx |

1. **Expecting all sponsors to implement soft POS safety edits (which can be overridden by a pharmacist) based on duplicative therapy of multiple long-acting opioids, and request feedback on concurrent prescription opioid and benzodiazepine soft edits. (Page 204)**

This is one of several soft edits (meaning it can be overridden by the dispensing pharmacist) that CMS is proposing. Essentially this would fire if someone was filling more than one long-acting opioid, irrespective if it is for a different strength of the same drug (i.e. methadone 10 mg and 5 mg together would cause the reject to fire).

We question the effectiveness of such an approach since the vast majority of pharmacists will override the reject merely to get the paid claim. A brief analysis of the most common soft edit we currently employ shows that > 80% of the time it fires, the dispensing pharmacist overrides (>90% when the medication is for pain [not limited to opioids]). We respectfully request CMS to consider other options that would be more effective.

Thank you for allowing us to provide these comments. We appreciate this opportunity to offer our perspective. If you have any questions or require any additional information, please contact me at stacey.harrington@priorityhealth.com or 616.464.8859.

Sincerely,

Stacey Harrington

VP, Senior Markets