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To: Centers for Medicare and Medicaid Services
Submitted electronically via: http://www.regulations.gov

From: Shannon Schuster
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Re: *Contract Year 2019 Plan Benefit Package (PBP) Software and Formulary Submission*

Attached are comments regarding the Contract Year 2019 Plan Benefit Package (PBP) Software and Formulary Submission.

Contract Year 2019 Plan Benefit Package (PBP) Software and Formulary Submission

Comments Submitted by
UnitedHealthcare
11/21/17

UnitedHealthcare (United) is pleased to provide the Centers for Medicare & Medicaid Services (CMS) comments regarding the Contract Year 2019 Plan Benefit Package (PBP) Software and Formulary Submission.

Plan Benefit Package: Section B
Inpatient Hospital-Acute Benefit Period (1a, Base 12)

In this section, the question "What is your Inpatient Hospital-Acute benefit period?" is disabled when the benefit is filed as $0 per stay or $0 days 1 - X. Further, if a plan files additional days with a cost share, the question is still disabled. United requests that this question be enabled for all scenarios so it allows us to capture consistent data across all benefit set-ups.

Inpatient Hospital Psychiatric Benefit Period (1b, Base 12)

In this section, the question "What is your Inpatient Hospital Psychiatric benefit period?" is disabled when the benefit is filed as $0 per stay or $0 days 1 - X. Further, if a plan files additional days with a cost share, the question is still disabled. United requests that this question be enabled for all scenarios so it allows us to capture consistent data across all benefit set-ups.

Cost Sharing Fields for Remote Access Technologies (14c)

In this section, the question, “Select the type of Remote Access Technologies offered (Select all that apply):” has been added to the Base 1 screen, with the option to select Web/Phone based technologies and/or a Nursing Hotline. However, there remains a single cost-sharing field for Remote Access Technologies. If CMS were to instead provide two separate cost sharing fields for Web/Phone based technologies and Nursing Hotline, MAOs would not need to file a cost share range in the service category. This would also eliminate the need for a note to explain which cost shares apply to each service. Therefore, United recommends that CMS provide two separate cost sharing fields for Web/Phone based technologies and Nursing Hotline.

Supplemental Preventive and Comprehensive Dental (16a, 16b)

The dental sub-categories used in the PBP software are different from, but similar to, the American Dental Association (ADA)-defined categories for dental services. This causes some confusion with MA plans when deciding which services should be filed to accurately align with the plan's benefit offering. In an effort to more accurately align dental services offered under Bid Categories 16a: Preventive and 16b: Comprehensive Dental with the actual bid filing, United requests that CMS modify the bid software for 2019 to be consistent with the ADA’s code and category groupings.

For 16a, this would include:

- Diagnostic (D0100-D0999) – this category includes clinical oral evaluations and exams, xrays, oral radiology, and other diagnostic tests

- Preventive (D1000-D1999) – this category includes prophylaxis and routine teeth cleaning, fluoride, and other preventive maintenance services

For 16b, this would include each of the following ADA categories listed as separate benefit categories.

- Restorative (D2000-D2999)
- Endodontics (D3000-D3999)
- Periodontics (D4000-D4999)
- Prosthodontics - removable (D5000-D5899) and fixed (D6200-D6999)
- Maxillofacial Prosthetics (D5900-D5999)
- Implant Services (D6000-D6199)
- Oral & Maxillofacial Surgery (D7000-D7999)
- Orthodontics (D8000-D8999)
- Adjunctive General Services (D9000-D9999)

The category name and code ranges shown above correspond to the dental benefit categories and coding as established by the ADA, so it will be clear how the ADA groupings correspond to the PBP groupings. By detailing each of the ADA dental procedure categories in the bid under 16a and 16b, MA plans would be able to more clearly define the supplemental dental benefit to members in the evidence of coverage and prevent confusion at dental provider's offices.

Prosthodontics fixed and removable would be combined into the same bid category.

Note Fields

If a benefit has a cost share range, it is required to provide an accompanying note that explains the reasoning for the range. Currently, the PBP software allows the validation of a benefit entry that has a cost share range, but no accompanying note.

United believes that the following SNP type/plan type/benefits allow the user to exit validate without a note when a range is filled in:

- ISNP – All plan types - 7b, 14e, 16b, and 17a
- CSNP – All plan types - 7b, 14e, 16b, and 17a
- Non-SNP – All plan types - 7b, 14e, 16b, and 17a
- DSNP – HMOPOS, LPPO - 7b, 14e, 16b, and 17a
- DSNP – HMO - 7b, 14e, and 16b
- DSNP –RPPO - 7b, 16b, and 17a

Since a note is required when a range is filed, United believes it would be beneficial for the PBP software to prevent validation, or at least display a warning message (reminding the plan to include a note), before allowing validation.

Plan Benefit Package: Section C
Skilled Nursing Facility (SNF)

There do not seem to be validation rules applying to the day ranges for Skilled Nursing Facility in Section C of the PBP software. For example, the PBP software allows the user to exit and receive no validation errors with the following SNF entries:

- End Day Interval 1 equals Begin Day Interval 2
- Begin Day Interval 2 equals 21, and End Day Interval 2 equals 20

There are rules for the day ranges in place for Inpatient Hospital Acute and Inpatient Psychiatric (OON and POS), so it seems that the same rules could also be used for SNF. United recommends that there be validation checks/rules for the day ranges for SNF similar to those for Inpatient Hospital Acute and Inpatient Psychiatric.

Number of Out-of-Network Groups

The current limit on the number of Out-of-Network groups in Section C has negatively impacted United's ability to enter intended benefits in the cost sharing fields. When we reach the limit, we must file benefits in out-of-network that do not align with their intended cost share. A note is then added to explain which cost share is applicable to each benefit. United requests that CMS increase the limit of out-of-network groups, or eliminate the limit in the PBP software altogether. This would allow out-of-network plan benefits to be more accurately captured in the filing, reduce the number of filed notes, and provide better data for members in Medicare Plan Finder and the Medicare & You Handbook.

OON/POS Pick Lists (14e)

The 14e benefits are grouped together as one benefit in Section C. This often leads to a range being filed for out-of-network with a note explaining which cost shares apply to each 14e service. The benefits in 14e: Other Medicare-covered Preventive Services have been broken out in the Section D plan-level picklists as 14e1, 14e2 and 14e3. United seeks clarification from CMS on whether this split out would be possible for the OON and POS Group pick lists; breaking out 14e in the out-of-network pick lists would allow for a one to one filing, as is done for the in-network cost shares.

PBP Data Reports

United noticed that the "Export to PDF" option was removed from the 2017 PBP software. To obtain a data report in this format, one must now export to Excel, open the Excel file, and then convert to PDF. We believe that these extra steps can add a significant amount of time to the process. United respectfully requests that CMS add the "Export to PDF" functionality back into the PBP software.

Skilled Nursing Facility Benefit Period (2, Base 10)

In this section, the question "What is your SNF benefit period?" is disabled when the benefit is filed as $0 per stay or $0 days 1 - X. Further, if a plan files additional days with a cost share, the question is still disabled. United requests CMS enable this question for all scenarios so it allows plans to capture consistent data across all benefit set-ups.

Plan Benefit Package: General
Copy Plan

Currently, the copy (plan to plan) function in the PBP software for Group plans will copy over the values. When one plan is copied to many, only one of those plans will show as "Plan Ready for Upload." We believe that all plans should update to "Plan Ready for Upload" in this scenario and not require an additional "Exit Validate." United respectfully requests CMS update the PBP software to function for the Group plans, as it does for the Individual plans.

Group plans do not require Sections B and C to be filled out with standard bids. However, there were a few instances in recent years when copying from one Group plan to another (or multiple) would cause Sections B and C to open and be "required" entry points. For that reason, we ask CMS to please ensure that the copy plan (same year) feature in the PBP does not open up Sections B and C for Employer Group Waiver Plans (EGWPs) (800 series) PBPs.

Training Version of the Software

United asks CMS to provide a generic training version of final PBP software for development and internal review purposes by plans. Similar to the beta PBP software that is released, we ask that CMS provide a training version of the final PBP software that does not require a “real” user identification. This would be for local use only with samples of all plan types and use of “virtual” contracts similar to the beta software.

Authorization Question Updates

The authorization questions in Section B have been updated from "Enrollee must receive Authorization from one or more of the following:" with five selection options to "Is authorization required?" with "Yes/No" responses. It is now unclear whether plans are still expected to only file requirements that are the responsibility of the member and might impact benefit coverage, or if CMS is asking plans to enter prior authorization (PA) requirements that might be in the provider contract and impact the provider payment, but would not impact a member’s benefit coverage. United asks CMS to specify what it would like entered for PAs.

Medicare & You

When the OON cost share aligns with the INN cost share, the amount is only printed once (ex. $10 instead of $10/$10). However, this may cause confusion for members when looking at an HMOPOS that does not cover all benefits OON because this scenario also only prints one cost share (ex. $10 instead of $10/Not Covered). We recommend that the INN and OON cost shares (or "Not Covered" if a benefit was not filed on a plan) for PPO and POS plans both be printed. Additionally, United requests CMS add an indicator or display for when the Maximum Out-of-Pocket is unlimited (e.g., H5652-006).

Medicare Plan Finder

Currently, supplemental benefits do not specify that they may be periodicity limited (e.g., Transportation, routine foot care (H0543-166)). United requests CMS pull in/import the benefit's filed periodicities from the PBP to the Medicare Plan Finder to provide better data for Medicare eligibles.

Additionally, the filed urgent care coverage is printable, yet if the plan also covers urgent care worldwide only, "always covered" is added to the view versus also including the separate and different cost share for urgent care worldwide (e.g., H0543-138). United asks that CMS pull in/import the filed cost share for worldwide urgent care from the PBP to the Medicare Plan Finder to provide better data for Medicare eligibles.

We have found that the sentence "There may be limits on how much the plan will provide." is not printing for Hearing services, dental services and vision services on this plan (e.g., H0543-138) when it has specific benefit periodicities. However, this sentence is showing up on other plans (e.g., H8748-009, H5322-028). United requests that all plans display "There may be limits on how much the plan will

provide." next to benefits in Medicare Plan Finder when applicable, or that CMS pull in/import the benefit's filed limits and periodicities from the PBP.

For plans H8748-008, 011:

- Plan 8 uses "per visit" for Primary Care, while plan 11 uses "copay"
- Plan 8 lists displays $10 for hearing exam, while plan 11 has $0 copay
- Plan 11 uses "copay" after every preventive dental cost share, but only lists the cost share (leaving off "copay") for comprehensive dental.

United recommends that CMS use consistent verbiage across all plans in Medicare Plan Finder to mitigate any possible confusion for Medicare eligibles.

Furthermore, MS$0 DSNP does not include "always covered" next to emergency and urgent care cost share. This plan (H0169-001) covers these benefits worldwide as well. For consistency across all plans in Medicare Plan Finder, United asks that CMS display "always covered" next to emergency and urgent care cost shares for MS$0 DSNPs that have worldwide coverage.

When Medicare-covered benefits are filed with a referral requirement and the supplemental benefits are filed without a referral, the supplemental benefits are incorrectly displaying referral required. For example:

- Hearing Exam (H0543-166)
- Comp Dental (H0543-166)
- Vision Exams and Eyewear (H0543-166)
- Foot care/Podiatry (H0543-166)

United asks CMS to add additional referral questions to the PBP software that are specific to Medicare covered benefits and supplemental benefits. Breaking the referral question out in this way would allow for a more accurate filing, reduce the number of filed notes, and provide better data for members in Medicare Plan Finder.

Formulary Submission

Following the annual formulary submission for CY 2017, CMS changed the timing for submitting criteria update requests during the calendar year. Criteria update requests were required to be submitted prior to the release of the monthly formulary reference file (FRF). This change in timing does not provide plan sponsors the opportunity for criteria updates during the submission window immediately following the receipt of a monthly FRF. As a result, monthly formulary submissions receive line-level rejects when criteria does not match the monthly FRF. The timing change for criteria update requests causes unnecessary rework, review and resubmission for both the plan sponsors and CMS. For example, following the CY 2017 April monthly FRF, PA criteria change requests related to the April FRF were submitted by the May PA criteria deadline. This was followed a few days later by an HPMS email indicating a review concern for this same criteria related to the formulary submission earlier in the month when those criteria could not be updated.

United recommends that HPMS revert to the timing used in CY 2016 for submitting criteria update requests. Reverting to a date similar to that used during CY 2016 (by 9am PST on the last day prior to the monthly formulary submission window) would allow for criteria updates following the release of a

monthly FRF to be submitted during the related formulary submission window. The ability to submit the PA criteria change requests after the FRF is received will provide the opportunity for sponsors to update PA criteria during the submission related to that FRF. This will also avoid the related criteria review concerns that occur because plan sponsors did not have the opportunity to update those criteria during the submission immediately following the monthly FRF release.

If you have any questions on these comments, please feel free to contact me at 920-661-6217.

Respectfully,

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