



January 16, 2018

The Honorable Seema Verma, M.P.H.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-4182-P

Dear Administrator Verma:

Thank you for the opportunity to submit comments on the proposed policy changes and updates for the Medicare Advantage (MA) and Part D prescription drug programs for 2019 (CMS-4182-P). The Healthcare Leadership Council (HLC) welcomes the opportunity to share its thoughts with you.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable, high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

MA currently serves 19 million beneficiaries (33% of the total Medicare population)¹ and this number continues to grow as the program appeals to new beneficiaries whose previous employer-sponsored health coverage resembled MA. MA plans offer beneficiaries choice, accessibility, and affordability. In addition, MA provides benefits that enable early intervention, care coordination, and disease management tools, particularly for beneficiaries with multiple chronic conditions.

¹ The Henry J. Kaiser Family Foundation, October 10, 2017, "Medicare Advantage."
<https://www.kff.org/medicare/fact-sheet/medicare-advantage/>.

The Part D program's ability to keep prescription drug costs low has expanded access and increased medication adherence. This program also provides beneficiaries with options, because each year they can choose from many plans and find the coverage that works best for them. As a result, HLC's *Medicare Today* coalition's *2017 Senior Satisfaction Survey* found that nearly 9 in 10 seniors are satisfied with their Part D coverage and 8 out of 10 believe it is a good value.²

HLC thanks the Centers for Medicare and Medicaid Services (CMS) for being responsive to our suggestions on the Request for Information on transformative ideas for the MA and Part D programs. We urge CMS to support Medicare beneficiaries and ensure the continued success of the MA and Part D programs by implementing the following policies in the final rule.

Limitation on the Special Enrollment Period for Low-Income Subsidy Beneficiaries with an At-Risk Status

HLC asks CMS to modify its proposal to prevent a disincentive for dual-eligible beneficiaries (duals) to enroll in integrated MA-Prescription Drug plans. Specifically, we request that CMS continue to extend a Special Enrollment Period (SEP) to duals for the purposes of moving to an integrated plan option including a Dual Eligible Special Needs Plan (D-SNP) or Medicare Advantage-Medicaid Plan (MMP). The current monthly SEP is in the best interest of the dual eligible beneficiaries as well as important to joint marketing strategies, viable enrollment levels, alignment of Medicare-Medicaid enrollment under one plan sponsor, and consumer choice in states where integrated care options through D-SNPs and MMPs are being promoted.

Flexibility in the MA Uniformity Requirements

HLC supports CMS' proposal to allow MA plans to offer targeted supplemental benefits to medically vulnerable enrollees. By tailoring benefits to the beneficiary's health condition, plans will be able to improve care delivery, promote wellness, and achieve cost-savings for the Medicare program. These benefits will also encourage beneficiaries to be more engaged and compliant with their care. HLC supports the value-based insurance design (VBID) demonstration and appreciates that CMS has used its authority to expand certain aspects of VBID to all MA plans.

HLC encourages CMS to ensure that plans have sufficient flexibility to determine the criteria for offering tailored benefits. Rather than offering the same benefits to everyone with a particular diagnosis, plans should be able to tailor the benefits based on factors like the patient's state of health and level of disease severity. CMS should also enable plans to address social determinants of health by offering non-medical social services to beneficiaries, including transportation to medical appointments, access to healthy foods, and safe housing. Finally, HLC encourages CMS to consider adopting similar flexibility in Part D benefit plan design to allow changes that lower patient out-of-pocket costs for Part D drugs.

CMS should educate beneficiaries about the new types of benefits through resources such as the Medicare Plan Finder and 1-800-MEDICARE. CMS should also clarify that plans can

² Medicare Today, *2017 Senior Satisfaction Survey*, <http://medicaretoday.org/resources/senior-satisfaction-survey/>.

market these benefits to their enrollees. This will reduce confusion and help ensure that beneficiaries are able to choose the coverage that best meets their needs.

Maximum Out-of-Pocket and Cost Sharing Limits

HLC supports CMS' having flexibility to update the Maximum Out-of-Pocket (MOOP) and cost sharing limits for Medicare Parts A and B. This flexibility will ensure that values are set in a manner that allows beneficiaries to continue accessing affordable, sustainable, and non-discriminatory benefits.

However, HLC asks CMS to address the technical and operational issues associated with the encounter data system (EDS) before using encounter data to calculate MOOP limits or set cost sharing standards.

Meaningful Differences in MA Bid Submissions and Bid Review

HLC agrees with CMS' proposal to eliminate the meaningful difference requirement. This will help improve plan flexibility and encourage new and innovative benefit designs. HLC and its members stand ready to work with CMS to ensure that beneficiary resources like Medicare Plan Finder and 1-800-MEDICARE are updated in a manner that allows beneficiaries to easily compare their coverage options.

Coordination of Enrollment and Disenrollment Through MA Organizations and Effective Dates of Coverage and Change of Coverage

HLC thanks CMS for its proposal to codify the seamless conversion rules. We believe that this will help to ensure continuity of coverage for individuals newly eligible for MA who are enrolled in another plan offered by the MA organization. This is particularly important for the conversion of dual eligibles into D-SNPs, as these beneficiaries are high-need and high-cost, and many have cognitive difficulties. Seamless conversion will help ensure that they receive the best possible care.

For other beneficiaries, HLC recommends that CMS eliminate the proposed opt-in election process, as requiring beneficiaries to take this extra step does not meet CMS' goal of ensuring seamless conversion. HLC does, however, support an opt-out process that is complemented by additional beneficiary outreach requirements.

Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries

HLC supports CMS' proposal to passively enroll beneficiaries in an integrated D-SNP who are experiencing an involuntary disruption in their coverage. CMS should expand the types of D-SNPs that are eligible to receive passive enrollees.

MA and Part D Quality Rating System

HLC applauds CMS for outlining a set of guiding principles for the Star Ratings. These principles will help ensure that the Star Ratings incentivize quality improvement activities, accurately measure and calculate performance, and provide up-to-date quality information to beneficiaries and their families.

Measure-Level Star Ratings

HLC recommends that CMS reinstate the predetermined four-Star thresholds. These thresholds provide transparency and stability and enable plans to track achievement and set goals with their provider partners.

Star Ratings and the Categorical Adjustment Index

HLC urges CMS to develop a long-term solution for the Star Ratings and the Categorical Adjustment Index (CAI) that addresses the socio-economic challenges faced by MA low-income beneficiaries. MA plans should be incentivized for addressing socio-economic challenges as long as they are tied to improvements in beneficiary health outcomes, quality of care, and cost reduction.

Any Willing Pharmacy

HLC believes that preferred pharmacy networks can play an important role in controlling costs when developed properly, and while we encourage CMS in considering its definition of any willing pharmacy to guard that role, we also encourage CMS to consider how pharmacy quality measures approved and administered by a third party for appropriate patient populations might also be used to reward those pharmacies providing better patient care which ultimately lowers overall health costs to the Medicare program.

Eliminating the Requirement to Provide Prescription Drug Program Enhanced Alternative-to-Enhanced Alternative Plan Offerings with Meaningful Differences

HLC supports CMS' proposal to eliminate the Enhanced Alternative-to-Enhanced Alternative meaningful difference requirement because two plans could vary with respect to their benefits and plan design, but have similar out-of-pocket (OOP) costs. We agree that a meaningful difference that takes into account OOP costs be maintained between basic and enhanced plans, and strongly urge CMS to engage in a robust stakeholder review and comment opportunity should any updates to that OOP cost standard be considered.

Restoration of the Medicare Advantage Open Enrollment Period

The proposed rule reflects the 21st Century Cures Act's restoration of the MA open enrollment period (OEP) from January 1 to March 31. This legislation also prohibits unsolicited marketing and mailing materials to individuals eligible to enroll during the OEP. HLC is concerned that these requirements could cause confusion among beneficiaries as to when they can enroll in plans. We recommend that CMS undertake an extensive consumer education initiative on the OEP. Additionally, we ask CMS to issue additional guidance on unsolicited marketing and mailing.

Revisions to the Timing and Method of Disclosure Requirements

HLC applauds CMS' proposal to allow for the distribution of the required disclosure information through a website or email. Beneficiaries receive large amounts of paper in the mail about the MA and Part D plans. Providing these documents in electronic format would reduce waste, provide beneficiaries with a centralized repository of up-to-date documents, and lift a costly and timely burden from the plans. Beneficiaries could still receive the paper documents if they requested them.

Revisions to Parts 422 and 423, Subpart V, Communication/Marketing Materials and Activities

HLC supports CMS' proposal to define communications materials broadly while defining marketing materials more narrowly. This will allow for a less burdensome approach to communicating with beneficiaries.

Fraud Reduction Activities

HLC supports CMS' proposal to allow the inclusion of fraud prevention activities in the quality improvement activities of the Medical Loss Ratio (MLR). We also encourage CMS to include health information technology as an allowable expenditure, and specifically include activities such as claims code auditing, pre-pay coding, physician-profiling, and audit/recovery operations as fraud reduction activities. For ease of administration, we recommend that CMS consider extending these same changes to the regulations that govern the commercial and Medicaid markets.

Medication Therapy Management

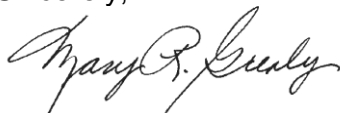
HLC applauds the inclusion of Medication Therapy Management (MTM) in the MLR as a medical expense. These programs increase medication adherence and improve health outcomes for Medicare beneficiaries with multiple chronic conditions and medications.

Physician Self-Referral (Stark) Law and Anti-Kickback Statute

In addition to the proposals outlined in the rule, HLC believes that CMS should issue additional safe harbors for the physician self-referral and anti-kickback laws in order to be able to deliver true value-based care that benefits the beneficiary. When these laws were enacted, the healthcare system provided little or no incentive to providers to coordinate healthcare delivery. Reimbursement models based on the number of services provided rewarded volume, rather than health promotion and maintenance. As a result, policymakers sought to restrict financial arrangements that could lead to overutilization, influence provider decision-making, and compromise patient care. However, as reimbursement models have evolved to become more patient-centered, these laws have become barriers to value-oriented care models that improve health outcomes and reduce costs.

Thank you again for your commitment to the MA and Part D programs. HLC looks forward to continuing to work with CMS on our shared priorities. Should you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435.

Sincerely,



Mary R. Grealy
President