October 27, 2017

The Honorable John R. Graham
U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team, Attn: Strategic Plan Comments
200 Independence Avenue, S.W.
Room 415F
Washington, D.C. 20201

Sent via electronic transmission to: HHSPlan@hhs.gov

Dear Acting Assistant Secretary Graham:

Thank you for the opportunity to comment on the Department of Health and Human Services' (HHS) draft strategic plan for 2018-2022. 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 health system that makes affordable, high-quality care accessible for 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.

HLC members support HHS' strategic goals of: 1) reforming, strengthening, and modernizing the nation's healthcare system; 2) protecting the health of Americans where they live, learn, work, and play; 3) strengthening the economic and social well-being of Americans across the lifespan; 4) fostering sound, sustained advances in the sciences; and 5) promoting effective and efficient management and stewardship. These priorities align with those outlined in HLC's strategic plan, and we look forward to continuing to work with HHS to advance these goals. Our ideas on a few key areas are described below. Additionally, I am attaching HLC's playbook of suggestions for the Administration and Congress that goes into greater detail on these topics.

Wellness

Like HHS, one of HLC's top priorities is chronic disease prevention and management. For example, HLC is a supporter of the Diabetes Prevention Program (DPP), which is a lifestyle change intervention that has been shown to prevent or delay the onset of type 2 diabetes. We applaud HHS for expanding this program into Medicare in 2018, and encourage the administration to consider DPP as a model for other chronic diseases.

Scientific Research

HLC asks the administration to help maintain America's leadership in the sciences by continuing to support the Precision Medicine Initiative and encouraging harmonization of federal data to better facilitate research. With an eye toward greater long-term affordability gained through more effective, targeted treatments and cures, there is an opportunity to achieve significant progress in the development and use of personalized medicine.

Health Coverage

HLC is committed to stabilizing the individual insurance market so that consumers have access to affordable and high-quality healthcare. We agree that HHS must reform burdensome regulations that raise consumer costs, and regulatory oversight of insurance products should be returned to the states since they understand best what their consumers need. Health plans and brokers should be able to directly enroll consumers in plans. In addition, HHS should work to attract young and healthy consumers to the marketplace by encouraging innovation and flexibility in plan design, and by ensuring that nonstandard plan options are presented to consumers in a way that does not penalize innovative plans.

HLC also supports HHS' efforts to educate consumers on health literacy and on their choice of coverage options including Medicaid managed care, Medicare Advantage, Medicare Part D prescription drug plans, and more. HLC members have worked to streamline the eligibility and enrollment processes for these programs.

Healthcare Workforce

Our nation's healthcare workforce must be strengthened and expanded to meet the changing demands of America's evolving healthcare system, as well as our growing and aging population. Physicians should work with nonphysician providers in interdisciplinary healthcare teams, and nonphysician providers should be able to practice to the full scope of their training and be reimbursed for such services. HHS should address the regulatory barriers that impair the mobility of the healthcare workforce. Additionally, increased funding for Graduate Medical Education (GME) is needed in both primary and specialty medicine to ensure that our nation has a well-trained physician workforce. HLC was also glad to see that HHS' strategic plan included provisions encouraging the use of Community Health Workers (CHWs) to connect patients to culturally appropriate care. These CHWs can help to address the social determinants of health by connecting patients to nonmedical social services such as housing, food, and transportation.

Dual-Eligibles

HLC urges HHS to improve Medicare/Medicaid program alignment for "dual-eligibles" (people who are eligible for both Medicare and Medicaid). Over nine million Americans make up the dual-eligible population. Two-thirds are low-income elderly, and one-third is under 65 and disabled. Medicare primarily pays for acute care and prescription drugs, while Medicaid generally helps to pay for Medicare premiums, cost sharing, and long-term care, as well as other nonmedical services such as transportation. Approximately 54 percent of dual-eligible beneficiaries have cognitive impairments and, therefore, often have greater healthcare needs and more difficulty navigating the healthcare system.

A lack of alignment and cohesiveness between the programs can lead to fragmented or episodic care for dual-eligibles. For example, the two programs have different enrollment periods, notifications, and appeals processes, which is often confusing to beneficiaries. Both Medicare and state Medicaid IT systems need to track dual-eligible individuals so that they remain enrolled in programs that serve them the best and preserve their benefits.

Integrated care can also provide the dual-eligible patient with a more satisfying healthcare experience and better health outcomes. In order to achieve value, health outcomes and access to care must be considered in developing integrated care networks; success cannot be measured solely on cost. Modern technologies, such as telehealth, are more cost-effective and scalable than in the past, and they should be utilized for enhanced coordination of care.

Stark and Anti-Kickback Modernization

Coordinated care requires modernization of the Stark, Anti-Kickback, and Civil Monetary Penalties fraud and abuse laws. When the Federal Anti-Kickback Statute (1972) and the Physician Self-Referral ("Stark") Law (1988) were enacted, the healthcare system provided few or no financial incentives to providers or patients to improve health or care delivery. Reimbursement models generally rewarded volume, based on the number of services provided, rather than health promotion and maintenance. These models naturally promote overutilization, which in turn increases costs. Through these two pieces of legislation, Congress sought to restrict financial arrangements that could lead to overutilization, influence provider decision-making, and compromise patient care. Both laws are quite broad, prohibiting financial relationships and arrangements that are permitted in other industries; the safe harbors and exceptions, though numerous, are extremely narrow in scope. As we continue to move toward quality-driven, value-based care delivery and payment models, challenges arise if these innovative models conflict with the outdated federal fraud and abuse legal framework. The new models encourage integration of care and payment coordination between and among providers and other industry stakeholders using financial incentives, such as shared savings, bonus payments, or risk-sharing arrangements. The legal framework must allow care delivery and payment models that encourage broader collaboration among stakeholders to accelerate ongoing improvements in care quality and patient safety, while reducing the rate of cost growth.

Data Access

HLC believes that as taxpayer-funded entities, government health agencies must ensure maximum public benefit from data collected through their operations. Although HHS has taken steps to reduce time lag and improve compatibility of the data it releases, there is still significant room for improvement. The government should eliminate agency data "silos," harmonize definitions across agencies, and allow appropriate access to data at minimal cost to organizations that are subject to consumer protection laws. This will enable organizations to develop novel ways to fight disease, improve the quality of care, reduce costs, and accelerate innovation—all to the direct benefit of patients.

Government data releases must also be conducted responsibly, with sufficient information to make its context clear. Cost data, for example, should always include corresponding quality data to allow for a true assessment of the value of products and services. This quality information must include metrics validated by healthcare experts in the private sector, as well as in government. Proprietary information should never be made public unless expressly permitted by the generating organizations. Consumers want to understand healthcare prices so that they can make informed decisions. However, "input prices" solely are not helpful in making these decisions. Consumers need prices at the point of service—the actual charge for an operation, a treatment, or a medication. Any cost data that is released by HHS should feature sufficient context and clarity to ensure that consumers are empowered to make judgments based on value.

Thank you again for your work on HHS' strategic plan. HLC appreciates HHS' commitment to protecting and improving the health of our nation, and we look forward to continuing to collaborate on our shared priorities. Should you have any questions, please do not hesitate contact Debbie Witchey at (202) 449-3435.

Sincerely,

Mary R. Grealy
President