June 9, 2017

The Honorable Pat Tiberi
Chairman
Subcommittee on Health
Ways and Means Committee
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Tiberi:

Thank you for your leadership on the Medicare Advantage (MA) program. As the Subcommittee on Health prepares to hold a hearing, the Healthcare Leadership Council (HLC) welcomes the opportunity to share our 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 – are committed to advancing a consumer-centered healthcare system that values innovation, accessibility, and affordability.

MA currently serves 19 million beneficiaries (33% of the Medicare population) and this group continues to grow. MA plans appeal to new beneficiaries because MA often resembles their previous employer-sponsored health insurance that provided catastrophic coverage and care coordination. MA plans give beneficiaries choice, accessibility, care coordination, and disease management tools, particularly for beneficiaries with multiple chronic conditions. HLC urges the Subcommittee to consider the following proposals that will strengthen this important program and enable MA to continue to be an affordable and high quality choice for Medicare beneficiaries.

<u>Special Needs Plans (SNPs)</u>
HLC asks the Subcommittee to permanently reauthorize the SNPs. These plans serve an important role for beneficiaries who are high-risk. SNPs allow beneficiaries access to care plans and provider networks designed especially for their health conditions. Making the program permanent would encourage broader replication of best practices and care delivery. HLC also recommends that the Subcommittee support legislation similar to the bill introduced in the last Congress (H.R. 4212, the "Community-Based Independence for Seniors Act"). This bill would create a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program that would provide home and

community based services (HCBS) to low-income Medicare beneficiaries who are unable to perform two or more activities of daily living. This program would improve care and eliminate the need for these beneficiaries to spend down their income and assets to qualify for Medicaid. They would instead be provided with home and community-based long-term care services and supports.

Program of All-Inclusive Care for the Elderly (PACE)

HLC supports the PACE program, which coordinates care for frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. The comprehensive medical and social services offered by this program enable PACE individuals to remain in the community. Payments under the program are capitated, which allows an interdisciplinary team of providers to deliver all of the services participants need rather than limit them to the services provided under fee-for-service (FFS) plans.

Telehealth Services

HLC believes that telehealth is an important tool to modernize the healthcare system, and supports waiving Medicare's geographic and technical limitations on the use of telehealth. The capitated payment structure in MA is well-suited to incentivize telehealth innovations. The basic benefit package for MA should include telehealth, and this benefit should not be limited to the amount of supplemental funds available.

Value-Based Insurance Design (VBID)

HLC is supportive of VBID structures that incentivize beneficiaries to use high-value services. MA plans should have the ability to offer incentives (for example, lower cost-sharing) for beneficiaries that use certain health services. These types of incentives engage patients in their care and lead to higher levels of compliance with healthcare recommendations.

Alternative Payment Models (APMs)

APMs under the MA program provide a higher level of care coordination and better outcomes. The Subcommittee should level the playing field between traditional Medicare and MA by giving physicians equal incentives to take part in an APM under MA.

Social Determinants of Health

HLC urges the Subcommittee to support policies that adjust for the social determinants of health of Medicare beneficiaries. As recommended by the National Academies of Sciences, Engineering, and Medicine (NASEM), HLC believes that Medicare payments should be adjusted for social risk factors. The academies identified four approaches that could be used to account for these social risk factors, including stratified public reporting by risk factors to identify which providers are serving these patients, adjustment of performance measures to standardize estimates of quality, adjustment of payments to providers, and the restructuring of payment incentives to reward improvement in quality or achievement of high-value care. [1] HLC agrees with NASEM

[1] National Academies of Science, Engineering, and Medicine, Accounting for Social Risk Factors in Medicare Payment (Washington, DC: National Academies Press, 2017).

that a combination of these methods, including changes to both public reporting and Medicare payments, would best account for the social determinants of health of Medicare beneficiaries. MA plans should be allowed to offer a wide array of supplemental benefits to address these social determinants, including nonmedical services such as transportation to medical appointments and access to healthy foods. The Subcommittee should encourage the use of Community Health Workers (CHWs) to link MA beneficiaries to these services.

Pilot Program

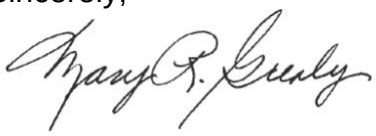
The Subcommittee should also encourage the Centers for Medicare and Medicaid Services (CMS) to test a new value-based payment and coordinated care delivery model for Medicare's sickest and costliest beneficiaries. This pilot would allow the most highly qualified MA plans and accountable care organizations (ACOs) to deliver integrated and coordinated care to the neediest beneficiaries.

Benchmark Cap

HLC urges the Subcommittee to acknowledge the work of MA plans with high star ratings by supporting legislation (H.R. 908, the "Medicare Advantage Quality Payment Relief Act") that would remove the benchmark cap. In 2016, the cap on benchmarks affected 72% of MA beneficiaries in plans with 4 or more stars and reduced the available bonus payments to those plans. This cap reduces incentives for MA plans to continuously improve the care they provide to their beneficiaries.

Thank you again for your work on the MA program. HLC looks forward to continuing to collaborate with you on this important issue.

Sincerely,



Mary R. Grealy
President