March 3, 2017

Patrick Conway, MD
Acting Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Sent via electronic transmission to: AdvanceNotice2018@cms.hhs.gov

Dear Acting Administrator Conway:

The Healthcare Leadership Council (HLC) appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) 2018 Advance Notice and Draft Call Letter. We applaud CMS for recognizing the value of Medicare Advantage (MA) and the Medicare Part D Prescription Drug program.

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 to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, 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.

We were pleased to see CMS propose the MA payment increase. MA now serves over 18 million beneficiaries (31% of the Medicare population) and continues to grow. These plans appeal to new Medicare beneficiaries because MA often resembles their previous employer-sponsored health insurance, which typically provided catastrophic coverage and better care coordination. MA plans have high beneficiary satisfaction levels that are rooted in choice, accessibility, and affordability. The payment increase will ensure that plans are able to continue to offer affordable premiums and attractive benefits. In addition, the MA program provides coverage that enables early intervention, care coordination, and disease management, particularly for beneficiaries with multiple chronic conditions. We urge CMS to continue this important work, and ask you to address the following issues in the final announcement.

Reduce Administrative Burden and Costs

CMS should work to reduce the burdens and costs of administering MA plans, and instead encourage increased flexibility in plan design.

Fee-for-Service (FFS) Normalization

HLC is concerned about the growth in FFS risk scores during 2015-2016. This population is large, and a substantial increase in morbidity needs further explanation by CMS. This is particularly important for the calculation of the end-stage renal disease (ESRD) normalization factor, since the growth in risk scores resulted in a substantial reduction in payments for a small, high-need population. We believe that CMS' predictive model is likely over-estimating the growth in FFS scores, which is leading to reductions in plan payments. To resolve this issue, CMS should discard the 2015-2016 data and recalculate the non-ESRD normalization factors. For ESRD, the adjustments for FFS and the normalization factor should be closer to each other to maintain stability for these very sick patients, perhaps by using last year's normalization factor as a base and then adjusting from there.

Coding Intensity Adjustment

HLC recommends that CMS suspend the annual coding intensity adjustment and review it so that it fully and equitably accounts for differences in coding between FFS and MA.

Encounter Data

The Encounter Data System (EDS) continues to be plagued by technical and operational challenges. HLC believes that CMS should not expand the use of this data until the reliability and accuracy of its extended use are verified to ensure that it does not inadvertently decrease overall risk scores and plan payments. We therefore recommend that CMS revert back to using 0% EDS data and this roll back should apply to 2016 as well. CMS should also not implement enforcement standards until this assurance is in place. Instead, CMS should heavily engage the healthcare industry in the development of monitoring standards.

Star Ratings

HLC believes that the Star Ratings play an important role in improving standards of care in the MA and Part D programs. However, HLC is concerned about how CMS links the Star Ratings and audit/enforcement actions. CMS' recent proposals blur the line between the Star Ratings program and the compliance continuum in a way that can lead to plans being held liable for a single issue in multiple different ways. The process needs to be more clear, accurate, and fair.

In determining the cut points between each star level, we believe that CMS should re-establish predetermined quality thresholds for star quality measures as this assists plans in understanding the targets necessary to achieve 4, 4.5, and 5 Stars.

It is also critical that the Star Ratings take into account the social determinants of health of MA beneficiaries. As recommended by the National Academies of Sciences, Engineering, and Medicine (NASEM), HLC believes that social risk factors should be adjusted for in MA. 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. HLC agrees with NASEM in that a combination of these methods, including changes to both public reporting and payment, would best account for the social determinants of health of MA beneficiaries. MA plans should also be allowed to offer a wide array of supplemental services that would help address the social determinants of health, including non-medical social services such as transportation to medical appointments and access to healthy foods. CMS should encourage the use of Community Health Workers (CHWs) who can link beneficiaries to these types of services.

However, it is also important to note that we need to avoid either creating a double standard of care or inappropriately lowering standards for chronic disease management. CMS should closely monitor the effect of any adjustment to the Star Ratings for potential unintended consequences—such as declining quality of care for low income/dual enrollee and disabled enrollees, or the potential risk of disincentivizing plans from enrolling these populations.

Risk Adjustment

HLC recommends that CMS refine the current risk adjustment methodology by adding codes recognizing disease states such as dementia and chronic kidney disease. Additionally, the 21st Century Cures Act allowed ESRD patients to join a MA plan, and CMS should make sure that payments for those patients are adequate.

HLC would like to bring to your attention new research conducted by Milliman that suggests that the recent changes CMS made to the Health and Human Services-Hierarchical Condition Categories (HHS-HCC) model should also be considered for the CMS-HCC model. As you know, the 2018 HHS-HCC model introduces 11 prescription drug-based diagnoses (RxCs) to impute a medical condition or indicate the severity of certain medical conditions. Milliman found evidence that longitudinal coding "leakage" is common in MA, which is a problem that the use of RxCs could ameliorate. Longitudinal leakage occurs when a beneficiary identified with a chronic condition has the diagnosis coded in claims in one year but not the subsequent year. These coding gaps mean that without investing in initiatives to identify these gaps, the MA plans enrolling patients with these conditions may be significantly under-reimbursed under the existing model.

Milliman analyzed 11 therapeutic classes as potential candidates to include in the next generation of the CMS-HCC model for MA. What Milliman found was evidence that prescription drug data can be used to impute diagnoses missing in medical claims. Many MA companies routinely use drug data to identify potentially missing diagnoses; this information is used by the MA plan to generate documentation for the diagnoses, which increases risk scores. Milliman also found that prescription drug data can help differentiate severity within a condition. Of the ten RxCs they analyzed, eight could help differentiate severity levels within certain HCCs. This can materially improve the accuracy of program payments for some conditions.

Overall, the Milliman study found that the predictive power of the hybrid HCC+RxC model would improve only modestly relative to the current HCC model, though that does not preclude a meaningful correction of payment for individual plans. We encourage CMS to review the Milliman study, and to consider adopting a hybrid HCC-RxC model for the MA program.

Benchmarks

CMS should adopt the recommendation of the Medicare Payment Advisory Commission (MedPAC) to calculate MA benchmarks based on beneficiaries enrolled in both Parts A and B. Since MA plans have to provide both A and B services, the benchmarks should be based on those services.

In addition, CMS should acknowledge the work of plans with high Star Ratings by removing the benchmark cap. The current cap on benchmarks affected 82.1% of MA beneficiaries in 4, 4.5, and 5 Stars Plans in 2016 and reduced the available bonus payments to those plans. This reduces incentives for MA plans to continuously improve the care they provide to their beneficiaries. HLC believes that CMS has the regulatory authority to reduce these caps.

Pilot Program for Medicare's Sickest and Highest Cost Beneficiaries

CMS should test a new value-based payment and coordinated care delivery model for Medicare's sickest and highest cost beneficiaries. This model would improve quality, reduce costs, and provide additional benefits for beneficiaries at a lower cost than FFS.

MA Bid Data Release

CMS should eliminate the provision in the Calendar Year 2017 Physician Payment Rule that allows for MA bid data to be released to the public. This release of information could help competitors to assess bid data submitted by other organizations, including those in the same geographic area.

Provider Directories

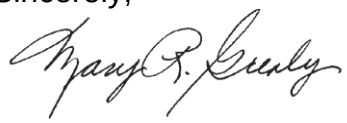
CMS should adopt a good faith compliance standard in regards to the accuracy of provider directories. MA plans spend considerable resources and time updating their directories but 100% accuracy is difficult to achieve because providers often have no incentive to update their profiles, site of practice, or availability.

Telehealth

CMS should eliminate originating site restrictions for telehealth to give MA beneficiaries more access to these services regardless of where they live. Telehealth improves healthcare quality and lowers costs, and also helps to address workforce shortages. Telehealth should be included in MA's basic benefit package and not limited to the amount of supplemental benefits the plans have available.

Thank you again for the opportunity to comment on the Draft Call Letter. HLC looks forward to continuing to work with CMS to ensure that the MA program is able to provide high quality, affordable care.

Sincerely,



Mary Grealy
President