May 8, 2018

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

Dear Chairman Roskam:

Thank you for your work on Medicare Advantage (MA). As the Subcommittee holds a hearing on this important issue, 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, 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 serves over 19 million beneficiaries (33% of the total Medicare population). This number has more than tripled since 2004,[1] and will continue to grow as the baby boomer population ages into Medicare and MA plans appeal to these newly eligible 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.

HLC thanks Congress for passing the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act as part of the Bipartisan Budget Act (Public Law 115-123). This important legislation improved MA plans' ability to serve chronically ill beneficiaries through programs like Value-Based Insurance Design,

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

telehealth, special needs plans, and supplemental benefits. HLC asks the Subcommittee to build on these reforms and continue to support MA by implementing the following proposals

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, over 2 million seniors were denied additional benefits or were not able to enroll in a high-quality plan because of the benchmark cap. This cap reduced the available bonus payments to plans with 4 or more stars, which lessens the incentive for plans to continuously improve the care they provide to their beneficiaries.

Medicare Plan Finder

The Medicare Plan Finder should be improved so that an "apples to apples" comparison of plans is available to all beneficiaries. This site is currently difficult to navigate and hard to understand, and it needs to be enhanced so that it allows for a better comparison of MA and traditional Medicare.

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

HLC supports moving toward a value-based payment and delivery system for healthcare. These new delivery and payment models are designed to encourage greater integration among providers and other healthcare stakeholders, which raises the need to address the current fraud and abuse legal framework to make it more compatible with value-focused health system transformation. HLC encourages the Subcommittee to address the Stark Law and Anti-Kickback Statute in the context of healthcare transformation, specifically where these laws create unnecessary barriers to the new integrated care models. Changes identified through this assessment may yield opportunities to amend fraud and abuse laws to foster healthcare arrangements that promote increased quality and lower costs. Furthermore, HLC recommends that Congress grant the Health and Human Services (HHS) Office of the Inspector General and Centers for Medicare and Medicaid Services (CMS) broad flexibility and discretion in developing exceptions and safe harbors to the Stark Law and Anti-Kickback Statute that are consistent with value-based care.

Alternative Payment Models (APMs)

APMs under the MA program are an important part of value-based care and provide a higher level of care coordination and better outcomes. HLC asks the Subcommittee to level the playing field between MA and traditional Medicare by giving physicians equal incentives to take part in an APM under MA.

Health Insurance Tax (HIT)

HLC thanks Congress for suspending the HIT in 2019 but asks that it be permanently repealed in order to prevent significant premium increases for MA beneficiaries.

Community-Based Care for MA Beneficiaries

HLC urges the Subcommittee to support H.R. 4006, the "Community-Based Independence for Seniors Act." This legislation would create a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration. The CBI-SNP program would provide home- and community-based services to low-income Medicare beneficiaries who are unable to perform two or more activities of daily living. This would improve their care and eliminate the need for them to spend down their income and assets to qualify for Medicaid. They would instead be able to stay in their home and community and be provided with long-term care services and supports.

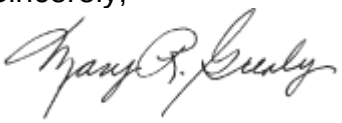
Wellness Programs

Chronic disease prevention is an essential component of healthcare. Many chronic diseases are caused by modifiable health risks such as lack of physical activity, poor nutrition, and tobacco use. To avoid these risks, Medicare beneficiaries need access to comprehensive and evidence-based wellness programs. Many of these programs have been implemented by employers, and retirees covered by MA should have access to similar programs.

HLC thanks CMS for expanding the Diabetes Prevention Program (DPP) into Medicare as of April 1. A CMS model test found that the DPP resulted in 45 percent of beneficiaries meeting the five percent weight loss target, which led to a reduction in the risk of developing type 2 diabetes.[2] However, HLC is concerned that virtual DPP was not included in the expansion into Medicare. Many MA beneficiaries live in areas that lack a DPP provider, and virtual DPP would be able to effectively serve them. MA plans should be given the flexibility to cover virtual DPP as a means of meeting their obligations under the expanded model. This will lead to lower rates of diabetes and better health for MA beneficiaries.

Thank you again for your commitment to MA. HLC looks forward to continuing to work with you on our shared priorities. Should you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,



Mary R. Grealy
President

[2] Seema Verma, "CMS Encourages Eligible Suppliers to Participate in Expanded Medicare Diabetes Prevention Program Model," The CMS Blog, April 30, 2018, https://blog.cms.gov/2018/04/30/cms-encourages-eligible-suppliers-to-participate-in-expanded-medicare-diabetes-prevention-program-model/.