March 5, 2018

Submitted electronically via http://www.regulations.gov

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: CMS-2017-0163

Dear Administrator Verma:

On behalf of the Healthcare Leadership Council (HLC), I am writing to share our thoughts on the 2019 Medicare Advantage (MA) and Part D Advance Notice and Draft Call Letter.

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.

HLC appreciates the Centers for Medicare and Medicaid Services' (CMS) payment and policy proposals to promote transparency, flexibility, and innovation within the MA and Part D programs. MA serves more than 19 million Medicare 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. These plans offer beneficiaries choice and affordability. Additionally, MA provides

[1] Gretchen Jacobson, Anthony Damico, and Tricia Neuman, "Medicare Advantage 2018 Data Spotlight: First Look," The Henry J. Kaiser Family Foundation, October 13, 2017, https://www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-spotlight-first-look/.

benefits that include early intervention, care coordination, and disease management tools, particularly for beneficiaries with chronic conditions. The Part D prescription drug program is also popular among Medicare beneficiaries. 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] This program's ability to keep prescription drug costs low for Medicare beneficiaries has expanded access and increased medication adherence. It has also provided beneficiaries with the opportunity to choose from many plans and find the coverage that works best for them. HLC encourages CMS to finalize proposals that support the continued growth and success of MA and Part D, while considering our below recommendations for other proposals that could negatively impact these important programs.

HLC members come from all healthcare sectors and touch the lives of Medicare beneficiaries in multiple ways. They have seen firsthand the positive impact of MA and Part D and urge CMS to continue to support these programs by addressing the following issues in the final Rate Announcement and Call Letter:

- Benchmarks
- Risk Adjustment Model
- Employer Group Waiver Plans
- Coding Pattern Adjustment
- Encounter Data
- Star Ratings
- Categorical Adjustment Index
- Supplemental Benefits
- Uniform Flexibility
- Health Risk Assessments
- Integrated Dual Eligible Special Needs Plans
- Medicaid Status Data File
- Medication-Assisted Treatment

Comments on Provisions of the Advance Notice

Benchmarks

HLC believes that CMS should improve MA payment accuracy by using fee-for-service (FFS) data only from beneficiaries who have both Medicare Part A and Part B to calculate MA benchmarks. MA beneficiaries are required to have both Part A and Part B, and the benchmark calculation should reflect that requirement. Using only Part A data distorts the benchmark since beneficiaries with Part A often have lower costs than those with both parts A and B.

[2] Medicare Today, "2017 Senior Satisfaction Survey," http://medicaretoday.org/resources/senior-satisfaction-survey/.

Additionally, HLC asks CMS to acknowledge plans with high Star Ratings by removing the benchmark cap. Beneficiaries in over 40% of counties are negatively impacted by the cap. This cap undermines the Quality Bonus Payment and leads to fewer benefits for MA beneficiaries. HLC believes that CMS has the regulatory authority to remove these caps.

Risk Adjustment Model

HLC supports adding mental health, substance abuse disorders, and chronic kidney conditions to the CMS-Hierarchical Condition Category (HCC) risk adjustment model. These changes reflect the requirements of the 21st Century Cures Act and more accurately account for the high health costs of patients with those conditions. We also urge CMS to explore adding conditions to the risk adjustment model that reflect social determinants of health.

HLC urges CMS to use the Payment Condition Count model that takes into account the total number of conditions of the patient. This will lead to changes in the MA contracts' risk scores that are more accurate and less varied than the All Condition Count model. We also ask CMS to begin implementing these changes in 2019, with such changes fully implemented for 2022 and beyond.

In addition, HLC requests CMS similarly phase-in its proposed changes to the end-stage renal disease (ESRD) risk adjustment model (i.e., starting in 2019, with full implementation final for 2022). We agree that recalibration of the ESRD risk adjustment model is long overdue, but we are concerned that this update results in yet another substantial reduction in payment for services provided to a small, high-need beneficiary population. Phasing the proposed changes in would provide year-over-year stability for the ESRD population.

Employer Group Waiver Plans

Over 3.5 million retirees are in Employer Group Waiver Plans (EGWPs), and this number has nearly doubled since 2010. These plans are attractive to beneficiaries because they offer comprehensive Medicare coverage and supplemental benefits, a nationwide network of doctors, and low premiums and out-of-pocket cost limits. HLC asks CMS to support these plans by freezing the implementation of the new payment methodology. This new methodology would result in higher costs for beneficiaries, reduced supplemental benefits, and fewer employers offering EGWPs. Instead of implementing the new methodology, CMS should calculate the bid-to-benchmark ratios separately for Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Coding Pattern Adjustment

CMS should not change its methodology until at least 2020, after providing detailed, advance notice of contemplated methodologies to stakeholders. The information provided in the 2019 Advance Notice for all three contemplated methodologies is outdated, insufficient, or both. Stakeholders need significantly more details about any

potential changes to the Coding Pattern Adjustment (CPA) in order to provide meaningful and accurate feedback

The first-and only-time CMS published its methodology for calculating the CPA was in the 2010 Advance Notice, which was released February 20, 2009. In the intervening nine years, the Medicare program (both FFS and MA) has changed considerably. Changes in enrollment, demographics, standards of care, treatment patterns, payment policies, and even legislation must be considered in first determining the relevance of the CPA and then, if appropriate, the level of the adjustment.

Encounter Data

A Government Accountability Office (GAO) report found that CMS has not fully validated encounter data.[3] GAO said, and HLC agrees, that complete validation is key to ensuring data quality. CMS should not expand the use of this data until the reliability and accuracy of its extended use is verified to ensure that it does not inadvertently decrease overall risk scores and plan payments. Until the data is fully validated, CMS should revert back to using 0% encounter data. HLC urges CMS to work with stakeholders in a transparent process to evaluate the data, address implementation barriers, and analyze stakeholder impacts.

Comments on Provisions of the Draft Call Letter

Star Ratings

HLC supports proposed changes to the Star Ratings and believes that these changes will help MA plans measure their improvements more effectively. Increased transparency on the improvement measures will help MA plans to better assess how they are improving care delivery. These measures should also be aligned across all public programs.

Categorical Adjustment Index

HLC agrees with the continued use of the interim Categorical Adjustment Index (CAI). We recommend that this CAI account for dual eligible status, as well as the Part D Low-Income Subsidy (LIS) and disability status. CMS should develop a long-term solution that addresses the socio-economic challenges faced by low-income MA beneficiaries.

Supplemental Benefits

HLC strongly supports CMS' proposal to expand the scope of supplemental benefits and urges CMS to include services that alleviate social determinants of health. These services could include, but are not limited to, safe housing, transportation to medical appointments, and access to healthy foods. These benefits will improve the health of vulnerable and low-income Medicare beneficiaries with chronic conditions. HLC also asks CMS to encourage the use of Community Health Workers (CHWs) who can link beneficiaries to these types of benefits.

[3] Government Accountability Office, "Medicare Advantage: Limited Progress Made To Validate Encounter Data Used to Ensure Proper Payments," January 2017, https://www.gao.gov/assets/690/682145.pdf.

Uniform Flexibility

HLC agrees with CMS' proposal on uniform flexibility. Medicare beneficiaries with chronic conditions need a plan that provides them with specific services and benefits tailored to their condition. For example, MA plans could reduce cost-sharing for diabetes medication for their patients with that disease, which will encourage compliance with treatment.

Health Risk Assessments

Like CMS, HLC believes that Health Risk Assessments (HRAs) are vital tools that can be used to manage care, improve health, and promote the efficient and effective use of healthcare resources. We support the use of HRAs in Rewards and Incentives Programs under MA so that Medicare beneficiaries will be motivated to complete these assessments.

Integrated Dual Eligible Special Needs Plans

HLC strongly supports CMS' proposals to improve beneficiary communications and reduce burden for Dual Eligible Special Needs Plans (D-SNPs). We agree that CMS should partner with states to align and integrate Medicare and Medicaid coverage for dual eligibles.

Medicaid Status Data File

HLC commends CMS for encouraging MA plans to inform providers about their enrollees who are qualified Medicare beneficiaries (QMBs) and their exemption from Medicare cost-sharing requirements. While the Advance Notice states that CMS's MA Medicaid Status Data File (MCMD) "provides the most current information about monthly dual status," HLC is concerned that the data file has gaps and inaccuracies that undermine MA plan efforts to inform providers about all levels of dual eligible status. Further, the data gaps inhibit MA plans from effectively helping QMBs and other dually eligible MA beneficiaries to gain and renew Medicaid eligibility. CMS should meet with stakeholders to remedy the shortcomings of this data file.

Medication-Assisted Treatment

According to a GAO report, in 2016, over 14 million Part D beneficiaries received an opioid prescription.[4] The current opioid abuse epidemic, and the risks the misuse of these drugs pose to Medicare beneficiaries, point to the need for an effective form of treatment for beneficiaries with an opioid addiction. HLC believes that CMS' proposal to provide access to Medication-Assisted Treatment (MAT) will help ensure that beneficiaries with substance use disorders get the help they need.

Network Adequacy

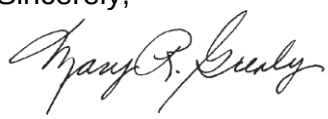
Although not addressed in the advance notice or call letter, HLC recommends that CMS encourage the offering of MA plans by adjusting its network adequacy standards to account for population differences within a county. This is necessary because even within a large metro county, there may be rural, low population areas. The lack of

[4] Government Accountability Office, "Prescription Opioids: Medicare Needs to Expand Oversight Efforts to Reduce the Risk of Harm," October 2017, https://www.gao.gov/assets/690/687629.pdf.

flexibility within the current county designation method limits the ability of MA organizations to offer products in areas where there is a greater need for such services.

Thank you for your commitment to the MA and Part D programs. 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