January 16, 2018

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
PO Box 8013
Baltimore, MD 21244-8013

Dear Administrator Verma,

Health Alliance Plan (HAP) is pleased to submit comments in response to the proposed rule on Medicare Advantage and Part D that was published on November 28, 2017.

HAP is a nonprofit health plan located in southeast Michigan. As a subsidiary of Henry Ford Health System, HAP is guided by a mission to enhance the health and well-being of the lives we touch. Currently, HAP and its subsidiaries serve more than 500,000 members through six product lines: group insured commercial, individual, Medicare, Medicaid, self-funded and network leasing.

We know that achieving our mission requires more than providing health insurance to our members. Providing access to great care to keep members healthy and help those with chronic illnesses keep their conditions under control is just the beginning. Health plans have the unique opportunity and responsibility to coordinate care in an efficient and effective manner that optimizes health outcomes across the entire health care experience – from routine office visits and preventive screenings to hospitals, pharmacies, worksites and at home.

We appreciate the general direction of the proposed rules – specifically the flexibility proposed and the elimination of outdated regulatory requirements. Furthermore, we do have some additional comments that we would like to share below.

Revisions to Timing and Method of Disclosure Requirements

The proposed rules offer to allow distribution of the Evidence of Coverage document, summary of benefits and provider directories through posting on a website or electronic delivery, if notice is provided of the availability of paper copies on request. We believe this is an appropriate and effective approach for distributing these important documents.

Communication/Marketing Materials and Activities

The rules propose to define communications and break out prohibitions into those that apply to all communications and those that apply to marketing. We would welcome this approach, as

current definitions are too broad and leave room for interpretation. Furthermore, this approach should reduce the administrative burden of complying with a pre-approval process for marketing materials.

Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes

The rules propose to permit Part D sponsors to immediately remove or change the preferred or tiered cost-sharing of brand drugs and substitute or add therapeutically equivalent generic drugs and permit implementation at any time of the year if certain conditions are met. We strongly support this change, especially when new generics are released into the market.

Request for Information Regarding the Application of Manufacturer Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale

The proposed rule includes a Request for Information soliciting comment on potential approaches for applying manufacturer rebates and all pharmacy price concessions to the price of a drug at the point of sale. The rebates we receive serve to reduce plan costs for all plan members. If we must apply the rebate at the point of sale, it would only benefit one member. Furthermore, it possibly serves as an incentive to fill brand over generic drugs – which could lead to CMS inflating its catastrophic costs. Accordingly, we oppose requiring rebates and concessions at the point of sale.

Star Rating Provisions

We support the proposal to keep new measures on the display page for a minimum of two years. For the drug adherence measures, CMS should allow for correction to the Proportion of Days Covered rates when members may be filling drugs outside their plan benefits (e.g., fail to present plan ID card to pharmacy, VA benefit). Finally, we recommend that CMS continue to reassess the value/reliability of CAHPS and HOS measures – which seem unstable at times.

We support establishing cut points, the proposed approach for calculating Star Ratings for consolidated plans, maintaining the existing methodology for the Parts C and D improvement measures, and the proposal for adding, updating and removing measures.

We urge caution in surveying physicians on their experience with the health plan. Many variables would have to be considered that could jeopardize the survey, including plan incentives and payment schedules, as well as utilization management and prior authorization programs – all of which may be adequate and appropriate but could still negatively impact a physician's perspective.

We would also urge caution in adding measures that focus on the use of new technology or improving beneficiary experience. A health plan cannot directly control such measures. Members may go to many areas to manage their wellness. We need to meet people at the channel of their choice and not force them into something that they are not comfortable with.

We also discourage increasing the weight of the patient experience/complaints. Many of the measures in this category are provider-driven or based on member perceptions – which a health plan cannot entirely control.

Finally, we believe that the contract level is still the appropriate place to calculate overall and summary Star Ratings. The plan level runs the risk of insufficient data. The parent level may be appropriate for some measures (e.g., appeals and complaints) but for many measures, it would be too broad and runs the risk of losing valuable insight on different products.

Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions

We strongly support the proposal to limit "at risk" beneficiaries to one or more providers and pharmacies. This allows plans the ability to oversee and help manage therapy, without making decisions about how to treat individual patients. However, we disagree with limiting the definition of a "frequently abused drug" to only opioids. Stimulant medications are highly addictive as well. Plan sponsors should be allowed flexibility in determining which controlled substances meet the definition of "frequently abused."

Changes to Days' Supply for Part D Transition Process

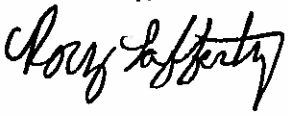
We strongly support changing outpatient transition day supply from "30 days" to "one month." Additionally, we strongly support reducing the transition days' supply for long term care setting from 91-plus days to the same as in the outpatient setting. We support this proposed timeline adjustment.

Lengthening Adjudication Timeframes for Part D Payment Redeterminations and IRE Reconsiderations

The rule proposes to increase the timeframe for issuing decisions on payment redeterminations and independent review entity (IRE) considerations from 7 to 14 calendar days from the date the plan sponsor receives the request.

HAP appreciates the opportunity to share our thoughts on this important proposed rule. If there are any questions or need for additional information, please contact me 313-664-8124 or rlafferty@hap.org.

Sincerely,



Rory Lafferty
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Health Alliance Plan