ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

January 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, SW
Washington, DC 20201

Re: CMS-4182-P, Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, Medicare Prescription Drug Benefit Programs, and the PACE Program

Submitted via Federal eRulemaking Portal

Dear Administrator Verma,

On behalf of the Johns Hopkins Advantage MD, a Medicare Advantage plan offering Health Maintenance Organization (HMO), Employer Group Waiver Plan (EGWP) and Preferred Provider Organization (PPO) products to approximately 12,000 Medicare beneficiaries in Maryland, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed policy and technical changes to the Medicare Advantage (MA) program for contract year 2019. In commenting on the proposed changes our health plan has the unique perspective from the front lines of delivering care to MA beneficiaries through our affiliation with Johns Hopkins Medicine and partnership with six health systems in the Maryland area. The Maryland MA market while still under penetrated has seen significant growth in recent years due in large part to the commitment from Johns Hopkins AdvantageMD.

The 2019 proposed technical changes to the MA program help address and take a positive step toward improving the MA beneficiary experience and increasing the efficiency of the MA program.

Marketing Materials

We were pleased to see proposed changes regarding the classification and distribution of marketing materials. Specifically, adding flexibility to the language in section 422.111(h)(2)(ii) to allow plans to provide information such as the Evidence of Coverage and the directories electronically via the plan website will allow smaller plans such as ours to utilize our resources and staff more effectively. Additionally, we have received comments from our members that the required materials (specifically the Evidence of Coverage and Provider Directory) are too heavy and have too many pages to be effectively used. We are supportive of the flexibility that CMS is proposing, with the goal of reducing the volume of materials that plans are required to mail to beneficiaries. We see these changes as an

opportunity to improve the experience of our members when utilizing these documents, reduce our shipping costs and burden, and increase our operational efficiency. Johns Hopkins AdvantageMD remains committed to providing our members with these materials in hard copy or alternate formats based on their needs.

We also appreciate that CMS is looking to narrow the definition of "marketing materials" to draw a distinction between materials that can influence a beneficiary's enrollment decision and materials that are used by the plan to communicate other important information to our members. Currently, we maintain an extensive library of documents that are submitted to CMS for review and approval, many of which are based on model documents with no significant revisions or are letters and communications of an operational nature such as outreach from a case manager or communications regarding premiums. We are supportive of CMS's efforts to streamline the document submission and review process by further defining what is required to be submitted as "marketing materials".

Special Election Period

Dual-eligible, LIS-eligible, and other potentially at-risk beneficiaries can be a challenging population in providing consistent, high quality health care. Beneficiaries are able to change plans on a monthly basis, which complicates care coordination and care management outreach efforts. The longer-term benefits of care management and pharmacy programs cannot be achieved without membership stability. The changes that are proposed for section 423.38(c) address these challenges, while balancing the efforts to ensure these beneficiaries have the power to select the best plan for their care.

The proposed changes align with the overarching Johns Hopkins mission of improving the health of the community, by restricting plan changes to once per year and enabling Advantage MD to form a stronger partnership with its members by engaging them in their health care over time and increasing participation in care management and pharmacy programs. We believe that if executed correctly, the proposed changes will lead to improved health outcomes in areas such as medication adherence, completion of critical preventative screenings, and improved coordination of high quality care for beneficiaries with serious health conditions or social barriers to getting care.

Part C & D Star Ratings

We welcome the change CMS proposes to make around the Part C and D Star ratings in Section 422.162(b)(3)(iii) of the proposed regulations to codify the methodology of the assigned Star ratings and to add requirements when contracts have consolidated. Moving to a structure where the Star ratings assigned would be based on the enrollment weighted average of the measure scores of the surviving and consumed contracts addresses the advantage large multi-state MAOs have currently in rolling poorer performing plans into the contract of higher performing plans and therefore receiving a qualified bonus payment (QBP) for the poorer performing plan. This change levels the playing field between the larger multi-state plans and those plans that have a much smaller service areas and will only give plans a QBP if they meet the CMS prescribed requirements in the area they serve.

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Flexibility in MA Cost-sharing and Premium Uniformity Requirements:

Johns Hopkins welcomes the proposed change to improve the ability for health plans to have greater flexibility in providing benefits for enrollees meeting specific medical criteria. This will strengthen the health plan's ability to provide affordable benefit options in the market while ensuring that the most vulnerable beneficiaries have access to benefits critical to manage their specific conditions.

Meaningful Differences Standard Elimination

Although we appreciate the intent of the elimination of the meaningful differences standard to allow plans to innovate and improve plan options, we are concerned on the impact on beneficiaries of too many choices without significant differences. We feel this change will only make it more confusing for beneficiaries to make plan choices. In our experience navigating the insurance landscape is challenging especially for the typical Medicare beneficiary. The meaningful differences standard allows for multiple plan choices without the creation of plans that have minimal additional value for beneficiaries. We encourage CMS to take into account the potential impact of too many choices on the overall beneficiary experience.

In conclusion, we would welcome the opportunity to discuss our comments with your staff directly, should there be the opportunity to do so. We are thankful for the opportunity to comment on the significant positive changes CMS proposes to make for 2019 and look forward to continuing our partnership with CMS to deliver high quality care to Maryland Medicare Advantage members.

Sincerely,

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