

January 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Ms. Verma:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including nearly 90 of which offer health plans, and our 43,000 individual members, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule outlining 2019 contract year policy and technical changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit programs. CMS's comprehensive rule looks to support innovation in MA and Part D products through improvements in quality, accessibility and affordability so that the needs of Medicare beneficiaries are better met.

The AHA is generally supportive of CMS's ambitious agenda to promote improvements and innovation in the MA and Part D programs. The MA program is an important source of coverage for approximately one-third of Medicare beneficiaries while the Part D plans provide access to outpatient prescription drugs to more than 70 percent of Medicare beneficiaries. Approximately 50 AHA members sponsor MA plans, and nearly all members contract with MA plans to provide services to Medicare beneficiaries.

The AHA's specific comments address the following areas:

- Benefit design, enrollee protections and plan requirements; and
- Quality rating system.



BENEFIT DESIGN, ENROLLEE PROTECTIONS AND PLAN REQUIREMENTS

CMS proposes policy changes to add greater flexibility in plan benefit design, beneficiary cost sharing and beneficiary enrollment, as well as plan medical loss ratio requirements. **While the AHA generally supports CMS's proposals, we recommend that the agency exercise caution to ensure that added flexibility provides value and does not result in beneficiary confusion.**

Flexibility in MA Uniformity Requirements: CMS proposes to allow MA plans more flexibility in modifying benefits, cost sharing and deductibles for subsets of enrollees that meet certain medical criteria. MA plans would need to apply any variations to all enrollees who meet the criteria; non-discrimination requirements would continue to apply; and premiums would need to remain uniform. This option would be available to plans for the 2019 plan year.

CMS, through its innovation center, is currently engaged in the MA Value-Based Insurance Design (VBID) Model that allows MA plans to offer supplemental benefits or reduced cost sharing to enrollees with specified chronic conditions to help direct beneficiaries to high-value care. As of 2018, VBID is being tested in 10 states, and that number will grow to 25 states by 2019. The specified conditions include chronic diseases, such as diabetes and congestive heart failure, and behavioral and cognitive impairments, such as mood disorders and dementia. The AHA, in general, believes that a VBID approach holds great potential for improving enrollee health by better targeting needed services, and we support CMS's continued efforts to test such innovations in benefit design. **However, we recommend that CMS increase flexibility incrementally upon evidence that such an approach supports the desired outcomes.** For example, CMS could start by allowing flexibility up to the parameters established for the VBID model for 2019 with further expansion dependent on evaluation of the findings from that program.

Maximum Out of Pocket (MOOP) and Cost Sharing Limits: CMS proposes to modify existing regulations under which the agency establishes the MOOP limits, and annual cost-sharing limits on Parts A and B services to prevent discriminatory benefit design. MOOP limits and cost-sharing limits are based on Medicare fee-for-service (FFS) data and reflect a combination of patient utilization scenarios and length of stays or services used by average to sicker patients.

Currently, MA plans are required to establish limits on enrollee out-of-pocket cost sharing (deductibles, coinsurance and copayments but not premiums) for Parts A and B services that do not exceed annual MOOP limits established by CMS. These limits are intended to help ensure that enrollment by individuals who use higher-than-average levels of health care services are not discouraged from enrollment. MA plans that adopt a lower, voluntary MOOP are given greater flexibility in their cost-sharing requirements.

CMS proposes to use Medicare FFS data to establish annual MOOP limits and proposes to increase the voluntary MOOP limit by increasing the number of service categories that have higher cost sharing in return for offering a lower MOOP.

The agency will monitor for potential discrimination if a plan is targeting cost-sharing reductions and additional supplemental benefits for a large number of disease conditions, while excluding other higher-cost conditions. **The AHA strongly supports agency efforts to prevent and take action against any plan discrimination.**

Meaningful Differences in MA Bid Submissions and Bid Review: CMS proposes to eliminate the “meaningfully different” standard that MA organizations must meet if they offer multiple MA plans in the same county. The standard currently requires organizations offering MA enhanced plans and basic plans, in the same county, to identify meaningful differences in value. CMS states that eliminating the “meaningfully different” standard would allow plans to innovate and improve plan options by increasing competition and allowing more affordable options to beneficiaries.

As CMS notes in the rule, the principal concern with eliminating the “meaningfully different” standard is increased beneficiary confusion regarding plan options. The elimination of this standard, for certain markets, is likely to increase the number of plan options. While CMS, in the rule, outlines the various tools and resources currently available to support beneficiaries, they may prove to be inadequate. **The AHA is concerned that the risk of beneficiary confusion is not outweighed by the limited benefits plans would achieve through removal of this standard. This is especially true in light of the proposed changes to the uniformity requirements that will give plans far more flexibility. We also recommend that if CMS moves forward with this proposal that it engages stakeholders, particularly beneficiaries and beneficiary advocacy groups, before enacting it to explore better tools and resources to improve the beneficiary’s experience when choosing a health plan.**

Coordination of Enrollment and Disenrollment through MA Organizations and Effective Dates of Coverage and Change of Coverage and Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries: CMS proposes to modify the seamless enrollment process, with a particular focus on Dual Eligible Special Need Plans (D-SNPs). CMS would permit seamless enrollment into D-SNPs for eligible beneficiaries if several conditions are met, including those related to enrollee eligibility, state Medicaid program and CMS approval of the plans’ proposed seamless enrollment processes, and beneficiary notice requirements, among others. CMS also proposes an opt-in enrollment process for beneficiaries moving from commercial coverage to MA coverage. Finally, CMS proposes new passive enrollment options for dual-eligibles to promote integrated care and continuity of care.

Taken as a whole these initiatives could create an improved seamless enrollment process while protecting more vulnerable beneficiaries, such as dual beneficiaries, from loss of continuity of coverage through passive enrollment. Meaningful beneficiary communication will be key to successful implementation of these initiatives. **The AHA strongly recommends that CMS ensures that beneficiaries receive adequate notice of any change in enrollment and ensures mechanisms exist where beneficiaries or their advocates can get timely answers to their questions.**

Reducing the Burden of the Medicare Part C and D Medical Loss Ratio (MLR)

Requirements: CMS proposes to allow MA and Part D plans to include the amount of claim payments recovered through fraud reduction efforts that do not exceed fraud reduction expenses in the numerator of their MLR. In addition, CMS also proposes to expand the definition of quality improvement activities (QIA) to include all fraud reduction activities, including fraud prevention, fraud detection and fraud recovery.

Currently, CMS may impose penalties on MA and Part D plans for failure to have an MLR of at least 85 percent. CMS based the MA MLR rules on commercial MLR rules, which do not count fraud prevention activities as QIA. This approach allows for better alignment between the two markets. CMS proposes to change the definition of QIA to include all fraud reduction activities to incentivize plans to invest in such efforts. This would have the result of increasing the MLR numerator, making it easier for plans to meet the standard.

The AHA believes that the MLR standard is an important tool for CMS to hold health plans accountable for how premium dollars are spent. **CMS's primary responsibility should remain protecting consumers' and taxpayers' health care dollars, and the AHA urges CMS not to finalize its recommendation to allow fraud activities to be included in the MLR numerator.**

QUALITY RATING SYSTEM

MA and PDP Quality Rating System: CMS proposes to codify the existing Star Ratings System for the MA and Part D programs and seeks feedback on how to improve the program. Specifically, the agency seeks comments on how well the existing measures create meaningful quality improvement incentives. In addition, CMS seeks feedback on plans to develop a survey tool to collect standardized information on physicians' experiences with MA and Part D plans.

The AHA supports most of the star ratings measure addition criteria proposed by CMS. However, we urge CMS to strengthen its "alignment" criterion to better promote the "measures that matter" the most to improving outcomes and health. As currently written, the alignment criterion would prioritize those measures that already appear in other programs. We agree that using the same measure in more than one program can promote alignment and reduce duplicative data reporting, but only to the extent that those measures generate reliable, accurate performance results in each program. Moreover, health plans and providers along the care continuum often play complementary, but differing roles in advancing care, which may necessitate differences in measures. Thus, the AHA recommends CMS expands its alignment criterion so that it explicitly considers the extent to which measures align with high priority measurement topics. **In addition, the AHA supports CMS's plans to develop tools and mechanisms to understand better physicians' experience with MA and Part D plans.**

Thank you for the opportunity to provide comments on these important Medicare programs. Please contact me if you have questions, or feel free to have your team contact Molly Smith, vice president of policy, at (202) 626-4639 or mollysmith@aha.org or Molly Collins Offner, director of policy, at (202)626-2326 or mcollins@aha.org.

Seema Verma
January 16, 2018
Page 5 of 5

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President