January 16, 2018

Seema Verma

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-4182-P

PO Box 8013

Baltimore, MD 21244-8013

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

**RE: CMS-4182-P Medicare Program Contract Year 2019 Policy and Technical Changes**

Dear Ms. Verma,

We appreciate this opportunity to offer comments on the 2019 proposed policy and technical changes under the Prescription Drug Benefit (Part D) and Medicare Advantage (MA) programs, and certain provisions of the Comprehensive Addiction and Recovery Act (CARA) and of the 21st Century Cures Act.

Priority Health is a Michigan-based non-profit health plan nationally recognized for improving the health and lives of its members. Created nearly 30 years ago, we offer a broad portfolio of health benefit options for Medicare, Medicaid, employer group and individual plans. Currently we have more than 130,000 members in our Medicare Advantage plans in our 68-county service area in Michigan**.**

We respectfully submit the comments below, all of which pertain to the Medicare Advantage and Part D program.

1. Integration of CARA and the Current Part D Opioid DUR Policy and OMS (82 FR 56341-42)

CMS proposes to implement the CARA Part D drug management program provisions by integrating them with the current Part D Opioid Drug Utilization Review (DUR) Policy and Overutilization Monitoring System (OMS), which would be codified. By integrating the programs, plans can limit beneficiary access to coverage for such drugs through pharmacy lock-in, prescriber lock-in, and/or a beneficiary-specific point-of-sale (POS) claim edit after case management and notice to the beneficiary.

The authority to implement a drug management program is a welcome proposal, offering a real opportunity to impact prescription drug abuse. We are concerned, however, about integrating a new, forward-thinking policy with the current one due to the retrospective identification of potential at-risk beneficiaries. With the current opioid epidemic, the ability to identify potential at-risk beneficiaries can immediately thwart the unnecessary use of frequently abused drugs. Implementation of a drug management program such as the one defined in CARA could be beneficial if used with point-of-sale utilization management procedures such as prior authorization.

Currently, plan sponsors have the capability to account for prescribers by practice group (TIN). Pharmacy Benefit Managers are able to account for pharmacies by chain. Neither entity possesses both pieces of information, so in order to build an effective system; a multidirectional exchange of information would have to be established in order to identify members using the number of prescribers and pharmacies. We ask that CMS take this into account when finalizing the rule.

1. Definition of “Frequently Abused Drug,” “Clinical Guidelines,” “Program Size,” and “Exempted Beneficiary” (§423.100)

For 2019, CMS proposes to designate all opioids as frequently abused drugs except buprenorphine for medication-assisted treatment (MAT) and injectables. In particular, CMS asked for feedback on the approach not to include benzodiazepines, muscle relaxants or other non-opioid controlled substances. We recommend classifying both benzodiazepines and skeletal muscle relaxants as controlled substances under the Controlled Substance Act as criteria for identifying potential at-risk beneficiaries. In our experience, concurrent therapy of these agents can exacerbate opioid-induced respiratory depression and increase the risk for overdose, while other therapies are available without such risk.

As this is the initiation of a new program, we believe the clinical guidelines proposed (Option 1) are appropriate to allow for the best overall care and management of identified potential at-risk beneficiaries.

We agree that beneficiaries receiving palliative and end-of-life care should be exempted from the drug management program requirements and that the current capabilities are unable to identify such beneficiaries prior to manual case management review. Therefore, until those capabilities are created, we believe exceptions should be made at the plan level when such beneficiaries are identified.

1. Case Management/Clinical Contact/Prescriber Verification (§423.153(f)(2))

Please clarify whether the term “written” is defined as a postal letter, electronic letter, fax or any of the above. Due to the proposed contact requirement of three attempts by phone within 10 business days following written notification, we are concerned that plan sponsors will be making early and unnecessary calls to the prescriber(s) prior to the prescriber(s) receiving notification, if “written information” is defined as postal mail only.

1. Requirements for Limiting Access to Coverage for Frequently Abused Drugs (§423.153(f)(4))

We respectfully disagree with the proposed requirement to obtain a prescriber(s) agreement prior placing a limitation on frequently abused drugs. In our experience, a prescriber attestation alone does not and will not significantly impact inappropriate prescribing habits. Clinical reviewers for each identified potential at-risk beneficiary case are appropriately credentialed healthcare professionals. After meeting the other provisions of the drug management program and eliciting information from the prescriber(s), we believe the plan sponsor should have the authority to limit access to coverage of frequently abused drugs if deemed medically appropriate by the reviewing clinical staff. We encourage CMS to consider allowing the plan sponsor, through appropriately credentialed health care professionals, to implement the limitation if deemed appropriate either by POS edits or pharmacy lock-in. This alternative approach would not restrict the ability of a beneficiary or provider to appeal an adverse decision by the plan.

1. Limitation on the Special Enrollment Period (SEP) for Low-Income Subsidy (LIS) Beneficiaries with an At-Risk Status (§423.38)

We request that CMS clarify how imposing the SEP limitations to LIS-eligible beneficiaries, including those of at-risk status, will impact the 5-star SEP option. In instances where a beneficiary qualifies for multiple SEPs, how will a plan determine the order of acceptance? Will CMS provide any indicator in the BEQ response file that will alert a carrier if a member does not qualify for the “duals SEP”?

1. Special Requirement to Limit Access to Coverage of Frequently Abused Drugs to Selected Prescriber(s) (§423.153(f)(9) through (13))

We respectfully disagree with the proposed requirement to wait six months prior to limiting a beneficiary’s access to coverage of frequently abused drugs to selected prescriber(s), as a beneficiary’s plan may only be active for twelve months. Inappropriate utilization of frequently abused drugs should and can be addressed more efficiently. One approach for CMS to consider is to allow the limitation to selected prescriber(s) after only one failed approach using another measure (such as a wait-and-see approach or pharmacy lock-in) for three months unless the prescriber(s) agrees that an initial limitation at the provider level is appropriate.

1. Beneficiary Preferences (§423.153(f)(9))

Currently a plan sponsor is required to honor a beneficiary’s preference(s) with the following exceptions: (1) a beneficiary submits a preference for a non-network pharmacy(ies) in the case of a stand-alone PDP or a non-network pharmacy(ies) and/or non-network prescriber(s) in the case of a MAPD plan, and (2) the sponsor determines that preference would contribute to prescription drug abuse or drug diversion.

We respectfully disagree that a sponsor should be required to honor a beneficiary’s preference(s) in all circumstances outside of these exceptions, as this adds additional administrative burden to the plan sponsor without impactful results, and can lead to inappropriate care for the beneficiary. We believe sponsors should have the authority to deny a beneficiary’s preference(s) when the change is not related to or would not adversely impact the beneficiary’s reasonable access to frequently abused drugs, reasonable travel time, or cost-sharing.

1. Drug Management Program Appeals (§§423.558, 423.560, 423.562, 423.564, 423.580, 423.582, 423.584, 423.590, 423.602, 423.636, 423.638, 423.1970, 423.2018, 423.2020, 423.2022, 423.2032, 423.2036, 423.2038, 423.2046, 423.2056, 423.2062, 423.2122, and 423.2126)

We agree that using a formula based on the value of any refills for frequently abused drugs to calculate the amount-in-controversy will provide a greater probability for higher review, benefiting both the plan sponsor and the beneficiary.

1. Maximum Out-of-Pocket (MOOP) Limit for Medicare Parts A & B Services (§§422.100 and 422.101)

We agree with the proposed change whereby CMS would establish permissible changes in MOOP-related data and methodology in the call letter, and believe this will allow plans greater flexibility and increased competition in the market. We look forward to commenting on the actual changes that will be identified in the call letter.

1. Cost Sharing Limits for Medicare Parts A & B Services (§§417.454 and 422.100))

We agree with this proposed change. The encounter data combined with Medicare FFS data may provide average amounts for all Medicare beneficiaries, not just the sicker population.

1. Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review (§§422.254 and 422.256)

We request CMS to define key benefit design characteristics to which a plan sponsor will be held accountable.

1. Coordination of Enrollment and Disenrollment Through MA Organizations and Effective Dates of Coverage and Change of Coverage (§§422.66 and 422.68)

We support CMS’ proposal to codify modified requirements for default enrollments upon conversion to Medicare. We believe that widespread experience with managed care among the general population warrants a simplified election of the MA plan for an individual aging into Medicare who has been enrolled in health coverage provided by the same parent organization.

We appreciate that CMS is proposing to extend the period of time during which current non-MA members can use a simplified enrollment process into an MA plan through their ICEP. We see a continued challenge of determining when current non-MA members are ready for an MA plan. More people continue working past age 65, and as identified in the proposal, some are ready for MA due to disability before age 65. The proposal states that CMS does not share Medicare numbers with organizations for their commercial members who are approaching Medicare eligibility. We would inquire if there may be some mechanism whereby CMS provides a “clearinghouse” of sorts so organizations with non-MA members could be made aware when those members approach eligibility.

We support reassessing the regulation in five years.

1. Part D Tiering Exceptions (§§423.560, 423.578(a) and (c))

CMS is proposing to make regulatory changes to prohibit sponsors from excluding non-preferred generic-drug tiers from tiering exceptions. CMS rightfully points out that as the price of drugs has grown, formularies have gotten more complex, leading to expanded tiers that in some cases mix brands and generics, and multiple tiers for generic drugs. CMS proposes to base eligibility for tiering exceptions on the tier that contains the preferred alternative drug to the higher-cost requested drug, rather than based on tier labels established by the health plan. This would remove an existing loophole whereby we could exclude generic tiers, including non-preferred generic tiers, from the tiering exception system.

While, we appreciate the clarification on how brand-name drugs should be treated in the tier exception process we do not support the proposed recommendation as it undermines a plan’s ability to develop an evidence-based formulary that would also be cost-effective for its members. To further clarify, we do not support CMS’ guidance on tier exceptions as a whole because a plan cannot appropriately manage cost to their own plan while at the same time enhancing the quality of patient care by selecting the most appropriate medications with the goals of reducing treatment failures, adverse drug events and hospitalizations and improving patient adherence and health outcomes.. A plan goes through a thorough review process when reviewing formulary placement of a medication including a comparison of cost and clinical efficacy to other similar drugs. Drugs are then placed on tiers based on cost and relative clinical effectiveness to these other similar agents. The way the guidance is currently worded, tier exceptions are easily awarded, thereby undermining a plan’s thorough review process and ability to manage cost.

We also respectfully disagree with the proposed revised language at §423.578(a)(2), as we believe it is still unclear and will lead to continued inaccurate interpretation among plan sponsors. The newly revised language that, in CMS’ review, “bases eligibility for tiering exceptions on the lowest applicable cost sharing for the tier containing the preferred alternative drug(s) for treatment of the enrollee’s health condition” (82 CFR 56371) does not define what is a “preferred alternative drug” to treat the enrollee’s condition.

1. Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries (§423.38)

We support limiting the number of SEPs per year, as we believe too many SEPs create too much member churn, which undermines market stability and the bidding process.

We agree that the alternate solution is too complex, difficult to administer and difficult to explain to members. This would not be an ideal solution.

With regard to other limited circumstances where the dual SEP should be available, we support offering robust plans that members can choose the best plan for them without limiting their choice.

We do not have an alternative approach to offer for consideration in lieu of narrowing the scope of the SEP.

We believe the best way to educate the affected population and other stakeholders is to utilize agent and provider education/training and targeted outreach (phone or letter) to those beneficiaries who have used this SEP in the past and are still active.

1. Star Ratings: Medicare Advantage and part D Prescription Drug Plan Quality Rating System

CMS proposes to codify key aspects of the Part C and D Star Ratings methodology, including the principles for adding, updating, and retiring measures, and the methodology for calculating and weighting measures We support this proposal and believe this clarity and direction will assist plans in making continuous improvements while also increasing the stability of Star Ratings. We also support establishing annual modification notices in the Advance Notice and Rate Announcement. We agree that current procedures should remain in place through the 2020 Star Ratings.

We encourage CMS to continue incorporating measures that are within the health plan’s control. While a health plan can impact a member’s perception of it, some measures - especially those regarding providers - are outside of its control. Certain actions desired by CMS, such as implementing provider lock in for potential substance abusers, might cause a dip in member satisfaction.

We respectfully disagree with increasing the weight for CAHPS measures from 1.5 to 3. We support and value consumer measures, however more importantly we want outcome measures that are objective rather than subjective. The clinical outcomes measures provide consumers with results about a plan's ability to keep them healthy and treat their illnesses/conditions.

The Health Outcomes Survey (HOS) does not provide a reliable evaluation of patient experience, as it is subject to variables such as timing, memory, and patient physical and mental status when completing the survey. We recommend elimination of the HOS-based measures on improving or maintaining physical and mental health; these measures are too generic for use in the Star Ratings and few plans have demonstrated that they can consistently improve performance over time. If they are retained, however, we recommend they be weighted as process measures at 1.5.

We support the identification of cut points, as they can provide insight into performance throughout the year, leading to greater quality improvements.

We respectfully disagree with incorporating physician experience measures into Star Ratings. Ambiguity as to who within the provider’s practice would complete the survey, or even who could complete the survey given time constraints, could lead to skewed and unreliable data.

Given the variability of technology and the individual needs of each health plan, we encourage CMS to be thoughtful when introducing measures to adopt new technology. These should be thoroughly tested through display measures prior to their incorporation into Star Ratings.

Currently, CMS calculates Star Ratings at the contract level, which allows for statistically reliable measures while reducing administrative burden. However, contract consolidation has resulted in some contracts having disjointed market areas and artificially inflated Star Ratings. We encourage CMS to consider MedPAC’s September 2015 recommendations regarding consolidations and confining star ratings to single states ( “Factors affecting variation in Medicare Advantage plan star ratings” <http://www.medpac.gov/docs/default-source/meeting-materials/september-2015-meeting-presentation-factors-affecting-variation-in-medicare-advantage-plan-star-rati.pdf?sfvrsn=0>).

The effects of consolidation are particularly egregious when contracts are in distinct geographic areas and have different Star Ratings. When contracts are combined, the surviving contract determines the star rating of the new single contract, regardless of its enrollment size. For example, if two contracts each with 3.5 stars and 100,000 members are consolidated into a surviving contract with 5 stars and only 10,000 members, the newly formed single contract will be designated as having a rating of 5 stars. This means all 210,000 members are now enrolled in 5 star plans for purposes of bidding, quality comparison, and quality bonus payments. The MA plans offered under these contracts can be in different and noncontiguous states.

This practice not only costs the Medicare program, it reduces plan comparability related to quality and provides inaccurate signals to beneficiaries on which to base plan selections. Contract consolidations have made it increasingly difficult for health plans to benchmark their performance against competitors and differentiate their sustained and superior performance.

We are pleased that CMS has recognized this problem and has proposed a revised calculation of Star Ratings when a consolidation involves the same parent organization and plans of the same type. We support CMS’ proposal to mitigate the “cross-walking” of Star Ratings by assigning ratings based on the enrollment-weighted mean of the measure scores of the surviving and the consumed contract(s), for the first two years after consolidation. This will provide a more accurate picture of the performance of the underlying contracts both for beneficiaries when they evaluate choices and for the calculation of quality incentive payments.

We support the proposed rules for adding, updating, and removing measures. Measures would be proposed and finalized through notice-and-comment rulemaking, while technical and other non-substantive revisions would be accomplished through subregulatory actions.

1. Revise the Definition of Retail Pharmacy and to Add a Definition of Mail-Order Pharmacy

CMS proposes to define “mail-order pharmacy” as “a licensed pharmacy that dispenses and delivers extended days’ supplies of covered Part D drugs via common carrier at mail-order cost sharing.” CMS proposes to define mail-order pharmacy to clarify that a retail pharmacy that has a line of business that offers home delivery should not be classified as a mail-order pharmacy by sponsors. CMS also proposes to redefine “retail pharmacy” to mean “any licensed pharmacy that is open to dispense prescription drugs to the walk-in general public from which Part D enrollees could purchase a covered Part D drug at retail cost sharing without being required to receive medical services from a provider or institution affiliated with that pharmacy.”

We support the proposed revised definitions as the addition of the concept of “walk-in” would expand how the definition of retail pharmacy has historically been interpreted to include all community and independent based pharmacies that are open to the general public.

1. Timing of Contracting Requirements

We believe the current contracting process already accommodates the timelines proposed by CMS.

1. Changes to the Days’ Supply Required by the Part D Transition Process

We support the proposed revision of the required transition days’ supply in the LTC setting.

1. Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes (§§423.100, 423.120, and 423.128)

CMS proposes to change the transition supply requirements for long-term care patients from 91 – 98 days to 30 days due to concerns with waste and costs. CMS also makes a minor adjustment and clarifies the transition supply requirements for outpatient is one month and not necessarily 30 days to account for medications that are packaged as 28 day supplies. We support increased flexibility to implement midyear formulary changes in the interest of permitting plan sponsors to utilize generic drugs as they are approved by the FDA.

1. Treatment of Follow-On Biological Products as Generics for Non-LIS Catastrophic and LIS Cost Sharing

We support the classification of biosimilars as applicable (generic) drugs under Medicare Part D. We request clarification, however, as to the way in which biosimilars would be treated in the coverage gap for non-LIS beneficiaries. Would the brand coverage gap discount or the generic discount apply? Would the manufacturer of the biosimilar need to be enrolled in the Coverage Gap Discount Program?

Without careful evaluation of cost, the inclusion of follow-on biologics under the generic classification could have significant consequences – the biosimilar can end up being more expensive than the reference product. Currently, many follow-on biologic products have the potential to be rebate-eligible. Requiring plans to list follow-on biologic products within a typical generic tier may have unintended consequences on other medications covered in that class. While the follow-on biologics may be viewed as a type of generic, their costs are still very comparable to the reference product and they tend to maintain higher pricing due to limited competition in the market.

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

We strongly oppose this recommendation. Our special arrangements have not only lowered member premiums as mentioned, but have also resulted in lower member copays. This is a point-of-sale discount that’s beneficial across all tiers.

In addition, the proposal would further complicate an already complex process, resulting in increased pressure to raise premiums. Competing plans will have to follow our lead in order to remain competitive. In a very short time, market dynamics will resolve the concerns expressed by CMS related to the allocation of these rebates.

We believe this guidance would impact how formularies are tiered with the addition of manufacturer and drug-specific rebate tiers at point of sale and how preferred networks are managed for direct and indirect remunerations. The additional work would drive up costs that would be passed on to the patient through higher premiums.

In summary, the proposal would result in a substantial increase to our members; premiums and cost sharing obligations.

1. Restoration of the Medicare Advantage Open Enrollment Period (§§422.60, 422.62, 422.68, 423.38, and 423.40)

CMS proposes to codify a new open enrollment period (OEP). During that time, individuals enrolled in an MA plan would be allowed to make a one-time election to switch MA plans or to disenroll from an MA plan and obtain coverage in original Medicare. We support additional flexibility for beneficiaries but believe that safeguards will be necessary. We are concerned that an expanded enrollment period will encourage some brokers to aggressively market to beneficiaries who have already chosen a satisfactory plan.

In order to safeguard beneficiaries, we recommend that beneficiaries have the choice of either returning to their plan from the previous year, if they have changed plans, or moving to Original Medicare with Part D coverage during this period. This approach will allow beneficiaries the option of correcting a coverage decision with which they are not satisfied and will reduce the opportunity for agents in search of increased commissions to market coverage that may not meet the needs of the beneficiary.

1. Revisions to Timing and Method of Disclosure Requirements (§§422.111 and 423.128)

We support CMS’ proposal to incorporate the concept of “Communications Material” into MA guidance.

Furthermore, we generally support the electronic delivery of documents as it alleviates plan burden, decreases administrative costs, and reduces the number of mailed documents that beneficiaries receive from plans.

1. Prohibition of Marketing During the Open Enrollment Period

Plans conduct marketing activities throughout the year related to individuals aging in to Medicare; we understand that this can continue as long as it does not overtly encourage current Medicare Advantage members to change plans during OEP.

1. Lengthening Adjudication Timeframes for Part D Payment Redeterminations and IRE Reconsiderations (§§423.590 and 423.636)

We support CMS’ proposal to change the adjudication timeframe. Because the beneficiary would have already received the medications, allowing the plan 14 days instead of seven to process the payment reconsideration request would allow the plan to prioritize coverage determinations and make decisions regarding access to medications instead of payment reimbursements. This would ensure adequate resources are directed to processing more time-sensitive pre-service requests where the beneficiary has not yet obtained the drug, particularly during periods of increased case volume.

1. Elimination of Medicare Advantage Plan Notice for Cases Sent to the IRE (§§422.590)

We respectfully disagree with the elimination of the notice for cases sent to the IRE. With regards to the requirement that a beneficiary must wait 120 days after submitting an appeal to receive a determination (60 days for the plan to make its decision, and another 60 days for the IRE), we propose plans continue to send the beneficiary a copy of the decision letter detailing the reasons for denial as well as the location in their EOC where the information can be found.

1. Part D Prescriber Preclusion List

Due to the complexity of this rule and the lengthiness of both the rulemaking process and release of technical guidance, it is highly unlikely that we will be able to implement these requirements by January 1,2019. We therefore recommend that CMS delay the date of implementation or establish a good faith compliance standard for this requirement for calendar year 2019.

The proposed 3-month provisional supply of medicine raises concerns about overutilization and cost. While patients must have access to critical medicines, dispensing a shorter supply, such as one month, can meet that immediate need and allow them ample time to find an authorized provider. We recommend that a longer supply be authorized on an exceptions basis if the beneficiary cannot obtain a prescription from an authorized provider.

1. Removal of Quality Improvement Project for Medicare Advantage Organizations (§422.152)

We support the removal of the Quality Improvement Project (QIP) as we believe it results in an unnecessary burden and is duplicative with other requirements.

1. Reducing Provider Burden – Comment Solicitation

As a health plan, we contribute to the burden placed on providers through our medical record retrieval processes for risk adjustment specific to retro (Medicare) or concurrent (ACA) chase lists generated each calendar year. This includes annual national RADV sample participation, internal annual data validation audits, HEDIS and quality retrieval process, and additional SIU audits.

At Priority Health, we’ve attempted to mitigate this burden by expanding our provider EMR access within our network, allowing us to retrieve medical records with limited impact to the provider. We coordinate our retrieval process internally to ensure that all departments are aware of the medical records archived, preventing duplication in the request and retrieval process.

Medical records are retrieved through onsite or remote EMR access, fax, electronic exchange through secure file transfer protocol (SFTP), or paper copies, which are then scanned into an electronic format.  On average, providers are given two to five months to retrieve the medical records requested specific to Medicare risk adjustment retrospective chases.  However, time frames are much shorter for RADV and HEDIS/quality, SIU and data validation medical record requests.  As a health plan we work to mitigate provider abrasion by sharing analytics that indicate if a provider’s EMR or EHR has a setup issue preventing them from submitting the appropriate diagnosis codes identified during a member encounter.  EMR/EHR truncation issues within the provider community contribute to the challenges with the medical record retrieval process. As we assist our provider community in recognizing and correcting this issue, the volume of medical record requests may be reduced.

In contrast, one of the items we see contributing to the provider burden is the 5010, 837 professional claim format, which allows for only 12 diagnosis codes compared to the inpatient claim format which allows for 25.  Often a Medicare Advantage beneficiary has more than 12 diagnosis codes identified during an office visit, however they are not captured for the health plan due to this claim format limitation. Allowing more than 12 diagnosis codes on the professional claim would result in a reduced volume of medical record requests from the provider community.

1. Reducing the Burden of the Medicare Part C and Part D Medical Loss Ratio Requirements (§§422.2420 and 423.2430)

We agree with reducing the burden of Medicare Part C and Part D MLR requirements.

1. Fraud Reduction Activities (§§422.2420, 422.2430, 423.2420, and 423.2430)

We agree with all proposed changes including (1) removal of the current exclusion of fraud prevention activities, (2) the expansion of the current definition to include all fraud reduction activities including prevention, fraud detection, and fraud recovery and (3) the proposal to no longer include in incurred claims the amount of claim payments recovered through fraud reduction efforts up to the amount of fraud reduction expenses. We believe that including fraud, waste, and abuse expenses in the medical loss ratio (MLR) calculation, rather than treating them as administrative costs, will encourage plans to field more robust fraud detection programs and avoid efforts to scale back those activities.

1. Medication Therapy Management (MTM) (§§422.2430 and 423.2430)

We agree with this proposal for additional language surrounding MTM definition. We believe the inclusion of MTM programs in the MLR as a quality improving activity would further encourage and incentivize providers to strengthen their MTM programs, resulting in increased healthcare outcomes and decreased healthcare costs.

1. Physician Incentive Plans – Update Stop-Loss Protection Requirements (§422.208)

We support the review and modification of stop-loss tables on a more regular basis. We also acknowledge and appreciate the willingness to be flexible for alternative methods related to stop-loss standards, granted they can be actuarially justified.

1. Codification of Certain Medicare Premium Adjustments as Initial Determinations (§405.924)

We believe this would have minimal impact on Priority Health. This part of the process is between the beneficiary and Social Security Administration. Medicare Enrollment would only be impacted if a beneficiary loses Medicare Parts A and/or B and the notification is received via the daily TRR.

Thank you for allowing us to provide these comments. We appreciate this opportunity to offer our perspective. If you have any questions or require any additional information, please contact me at stacey.harrington@priorityhealth.com or 616.464.8859.

Sincerely,

Stacey Harrington

VP, Senior Markets