

VIA ELECTRONIC SUBMISSION: <http://www.regulations.gov>

January 16, 2018

The Honorable Seema Verma

Administrator

Department of Health and Human Services (HHS)

Centers for Medicare & Medicaid Services (CMS)

Attention: CMS-4182-P

P.O. Box 8013

Baltimore, MD 21244-8013

**RE: SCAN Health Plan Comments “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” (CMS-4182-P)**

Dear Administrator Verma:

SCAN Health Plan (SCAN) is pleased to comment on the Proposed Rule: *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 Program, and the PACE program*, issued November 16, 2017. SCAN appreciates CMS’s interest in enhancing Medicare Advantage (MA) and the prescription drug benefit.

We especially applaud CMS for asking plans to suggest improvements to the MA program in the 2018 Call Letter, and then actually proposing many of those suggestions in this new rule. Clearly, CMS has an open ear to what would make the program work better for beneficiaries. Especially noteworthy are the following proposals:

* Increasing Flexibility in MA Uniformity Requirements – this proposed interpretation would be a major step forward in tailoring health coverage to individuals’ needs;
* Codifying the Star Ratings – this would present a more rational approach that would help people with their plan selection process and provide plans with greater stability for planning purposes;
* Reducing Administrative Burden – this series of changes would allow plans to streamline communications and focus more time on providing quality health care to beneficiaries; and
* Integrating the Comprehensive Addiction and Recovery Act of 2016 (CARA) within Current Drug Utilization Review (DUR) – this would allow plan sponsors to better manage opioid overutilization, a dangerous and growing threat to America’s seniors.

SCAN is concerned with a few aspects of the proposed rule, in particular:

* Seamless Enrollment for Dually Eligible Individuals – this proposal would diminish beneficiary choice and unfairly disadvantage dually eligible individuals by enrolling them into plans that may not be of the highest quality available to them or best suited for their personal health needs; and
* Manufacturer Rebates and Pharmacy Concessions to Drug Prices at the Point of Sale – this would not reduce members’ out-of-pocket costs and may increase premiums because of the reduction in competition.

These issues and others are addressed in more detail below.

**I. SCAN Health Plan**

SCAN is a not-for-profit health plan that serves seniors through MA plans and institutional, chronic care, and dual eligible special needs plans (SNPs). Approximately 194,000 Medicare beneficiaries are enrolled in SCAN’s MA plans in California, making it the fifth largest not-for-profit Medicare Advantage Prescription Drug (MA-PD) plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high quality care to the most vulnerable Medicare beneficiaries, including those who live with multiple chronic conditions, are eligible for nursing home care, and experience difficulty performing activities of daily living. Enrollees benefit from SCAN’s partnerships with health care providers that engage with plan members to provide the right care at the right time, while maximizing beneficiaries’ ability to maintain their independence. We are proud that SCAN MA plans received a 4.5 star rating for plan year 2018.

**II. Medicare Part C Provisions**

**Flexibility in the Medicare Advantage Uniformity Requirements**

* Proposed rule: CMS is proposing to allow all MA organizations the ability to reduce cost sharing for certain covered benefits, tailor supplemental benefits to patient needs, and vary deductibles based on specific medical criteria as long as enrollees who meet the identified criteria are treated the same. MA plans can offer variations by each segment of an MA plan as long as benefits, premiums, and cost sharing are uniform within the segment.
* ***SCAN comments****:* SCAN strongly supports CMS’s proposal to provide flexibility in offering medical and supplemental benefits for members who meet specific medical criteria. Common conditions like diabetes and hypertension affect many aging beneficiaries, and a flexible benefit design would help improve health outcomes and positively impact health care spending. We believe this revised interpretation of the uniformity standard will be a major step forward in tailoring health coverage to individuals’ needs. We offer several additional recommendations:

First, SCAN recommends allowing plans to detail these specific benefits enhancements through materials such as Evidence of Coverage (EOC) and Summary of Benefits (SB), so that beneficiaries would be aware of how the plan design would meet their specific medical conditions. This would be in contrast to the value-based insurance design (VBID) demonstration which specifically prohibits announcing plan design for specific patient populations through sales and marketing materials.

Second, SCAN encourages CMS to allow the use of socio-economic determinants, such as homelessness, dual eligibility, and low-income status, as well as functional status, in determining benefit flexibility. Limiting eligibility to only medical/diagnosis factors fails to address key conditions that shape the health challenges that millions of beneficiaries face.

Third, SCAN urges CMS to extend this interpretation of the uniformity standard to Medicare Part D benefits as well as Part C benefits. Medication management is critical to maintaining patient population health and lowering health care costs.

**Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review**

* *Proposed rule*: CMS is proposing to remove the meaningful difference requirement that places limits on the variety of plans that a MA Organization is allowed to offer in the same county.
* ***SCAN comments:***SCAN agrees with the removal of the meaningful difference methodology in CY 2019. By removing this requirement, plans will gain greater flexibility to design the most appropriate benefits for its members. While the current restriction is intended to reduce the complexity of the MA market, at times it encourages benefit differentiation that is more artificial than organic. Removing this restriction is in keeping with the general direction of designing benefits that more accurately meet patient needs.

**Coordination of Enrollment and Disenrollment through Medicare Advantage Organizations and Effective Dates of Coverage and Change of Coverage**

* *Proposed rule*: CMS is proposing default/seamless enrollment for Medicaid beneficiaries into a Medicare plan offered by the same parent organization that offers the beneficiaries Medicaid plan.

***SCAN comments****:* SCAN opposes default/seamless enrollment because it denies beneficiaries’ right to select their own health plans, which has long been a cornerstone of the Medicare program. Individuals deserve choice, and that choice should not be restricted due to a beneficiary’s financial status. Today, many States place Medicaid beneficiaries into managed care plans without choice. In fact, the Medicaid plan that the State enrolled the beneficiary into may not be the plan that the beneficiary wants or would benefit from the most. Auto-enrollment into a Medicare plan offered by the same carrier would only perpetuate a beneficiary’s lack of choice. In addition, auto-enrolling dual eligibles may unintentionally direct them toward lower quality health plans and provider networks. Some of the nation’s highest ranking Medicare plans do not offer under-65 Medicaid plans and, therefore, would not be available for auto-enrollment, but only on an opt-out basis. This is inherently unfair to the dually eligible beneficiary.

It is no surprise that dual eligible auto-enrollment has had a troubled track record. In Los Angeles County, for instance, about 80 percent of dual eligibles have chosen not to participate in the Medicare plan selected for them through Cal MediConnect, California’s version of the Financial Alignment Demonstration. Many have instead moved away from integrated care to fee-for-service (FFS) Medicare. Forcing individuals into a plan they did not choose undermines integration, which otherwise should hold tremendous benefits for duals. It would be far better to actively educate Medicaid beneficiaries about the full range of Medicare plan options available to them when they become eligible for the program and then let them decide what is in their own best interest.

**Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries**

* *Proposed rule:* CMS is proposing a limited expansion of its regulatory authority in circumstances when beneficiary enrollment would be disrupted by changes in health plan participation. It would allow passive enrollment for full-benefit dually eligible beneficiaries from a non-renewing integrated D-SNP to another comparable plan.
* ***SCAN comments:*** As with the proposal directly above,SCAN disagrees with this provision. A beneficiary deserves the right to select a Medicare plan freely,no matter his or her financial status.

**Medicare Advantage and Part D Prescription Drug Plan Quality Rating System**

* *Proposed rule*: CMS is proposing 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.
* ***SCAN comments****:* SCAN applauds CMS’s efforts to codify the Star Ratings methodology because it will provide MA plans with greater stability, allowing them to develop multi-year initiatives by knowing the measures several years in advance. It also will help beneficiaries with their selection process by providing better information and more reliable results. In addition, SCAN recommends the following:

*Measurement Improvement*

SCAN recommends the following measure improvements:

*Impact on Older Beneficiaries*. CMS should specifically consider the impact of measures on older Medicare populations, especially those aged 85 and older, who may not benefit from certain treatments or testing. Currently, there are a few measures that are not appropriate for the older Medicare population because the risk of treatment may outweigh the benefit. Examples include the treatment of rheumatoid arthritis with disease-modifying antirheumatic drugs (DMARDs) and the diagnosis and treatment of osteoporosis post fracture. For this reason, treating physicians may resist following CMS measures, thus impacting plans’ 5 Star quality scores. SCAN recommends that for older populations CMS consult treatment guidelines endorsed by a wide variation of relevant medical organizations, such as the American Geriatrics Society, American College of Physicians and American Heart Association, and reflect that in the Star measures. Additional CMS-sponsored research in this area would be beneficial.

*Contract Level.* SCAN recommends keeping the Star rating at the contract level. Moving to the plan benefit package level for specific populations would add complexity that many plans would find extremely difficult to navigate.

*Survey Size.* SCAN recommends that CMS avoid including small outlier plans that affect threshold determinations, as small survey sizes may undermine accuracy. Instead, minimum membership or weighted clustering techniques should be considered.

*Greater Transparency*. SCAN would also appreciate greater transparency into star thresholds, with CMS releasing the thresholds a year in advance of the star rating.

*Reward High Performance Plans.* SCAN recommends that CMS reward plans that receive the same high score year after year and receive 5 Stars two years in a row, as an improvement. Plans that have already reached the top level of performance cannot achieve statistically significantly higher numbers because it is impossible to improve from 100 percent.  By not crediting plans with consistent high performance, CMS is actually penalizing these plans for “lack of improvement.”

*Socio-economic Factors*. SCAN urges CMS to incorporate socio-economic factors, i.e., homelessness, disability, dual eligibility, and low-income status, etc., into case-mix adjustments as soon as possible.

*Physician Experience*

SCAN has some concern regarding developing a survey tool for collecting standardized information on physicians’ experiences. This type of measure may not be well-suited for all models of care. Small survey sample sizes and subjectivity may lead to misleading physician experience scores that could negatively impact plans.

**Restoration of the Medicare Advantage Open Enrollment Period**

* *Proposed rule:* CMS is proposing that the MA open enrollment period (OEP) allow individuals enrolled in an MA plan to make a one-time election to go to another MA plan or FFS Medicare. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage.
* ***SCAN comments:*** SCAN agrees with the restoration of the OEP for CY 2019. This restoration would provide beneficiaries with additional time to make health plan decisions at the beginning of the year.

**Revisions to Timing and Method of Disclosures Requirements**

* *Proposed rule:* CMS proposes to separate the delivery date of the Annual Notice of Change (ANOC) from the EOC so that Medicare beneficiaries receive the ANOC first as a stand-alone document. Additionally, CMS would permit MA and Part D sponsors to provide certain materials, such as the EOC, electronically. Plans would still be required to provide beneficiaries with easy access to hard copy materials.
* ***SCAN comments:*** SCAN supports easing the requirement to mail the EOC/SB/Directories/Formulary because it will help reduce member confusion about the different materials and potentially save the program money. However, because a mailing is still required to inform members of how to access electronically these disclosure materials, separating the delivery dates of the ANOC from the contemplated notice (regarding electronic availability of the other disclosure documents) may be confusing to Medicare beneficiaries and would not be as cost effective because it requires two separate mailings.

To simplify the communication of this important information to Medicare beneficiaries, SCAN recommends that CMS push-back the annual mailing of the hard copy ANOC to October 15th of each year. This would enable plans to combine the ANOC mailing with the notification regarding the posting of the other member materials to the plan’s website, further streamlining and simplifying plan communications to Medicare beneficiaries. Delaying receipt of the ANOC until October 15th should not adversely impact Medicare beneficiaries, and plans would be able to use this extra time to perform additional ANOC accuracy and quality reviews.

In addition to supporting these proposed changes to the provision of disclosure documents, SCAN recommends that CMS apply this new approach to the Part C and Part D Explanations of Benefits (EOBs) that plans send (monthly/quarterly) to members. Plans should be able to notify members when their Part C and Part D EOBs are available electronically and can be accessed via its website. This change would help shrink overall program costs and reduce the volume of hard copy mailings presently sent to plan members. It would also address frequent beneficiary complaints about being inundated with too many mailings.

**Revisions to Communication/Marketing Materials and Activity**

* *Proposed rule:* CMS proposes to lessen the burden of marketing submission and review by focusing the definition of “marketing” on materials that are most likely to lead to an enrollment decision. To account for those materials that fall outside of the proposed new marketing definition, CMS proposes creating appropriate requirements and oversight for a new category of materials and activities called “communications.”
* ***SCAN comments:*** SCAN supports CMS’s proposed changes to distinguish between communication and marketing materials and activities, and to provide appropriate oversight of each.

**Removal of Quality Improvement Project for Medicare Advantage Organizations**

* *Proposed rule:* CMS is proposing to remove the Quality Improvement Project (QIP) requirements to eliminate redundancies with other plan efforts. MA requirements for Quality Improvement programs would remain in place.
* ***SCAN comments:*** SCAN supports the removal of QIP requirements. The implementation of the QIP requirements are complex and add to administrative burden. While CMS’s intention is to improve the focus on enrollee needs and subpopulations to improve quality, this is already being done as a part of the 5 Star program. For example, SCAN reviews each 5 Star measure and relevant display measure to conduct a subpopulation analysis based on race, gender, ethnicity (where available), language spoken, geography, and provider assignment. Our goal is to best understand the populations and deploy interventions to improve quality in a systematic “Plan, Do, Study, and Act” way. The removal of the QIP requirements would do nothing to impair this effort to improve quality.

**Changes to Agent/Broker Compensation Requirements**

* *Proposed rule:* CMS is proposing to make technical changes to remove outdated references in commission rules that were modified in 2014. For instance, CMS is formalizing the stipulation that renewal commissions are half of fair market value for the current year, not half of the fair market value at the time of enrollment.
* ***SCAN comments:*** SCAN agrees with the proposed technical changes, which we already adhere to.

**Changes to the Agent/Broker Requirements**

* *Proposed rule:* CMS is proposing to give plans more discretion than currently permitted in handling agent/brokers who become unlicensed. CMS is allowing more plan discretion when an agent conducts an enrollment without having a current state license.
* ***SCAN* comments**: SCAN agrees with this proposal and already complies with these rules in the rare occurrence when an agent allows his/her license to lapse.

**III. Medicare Part D Provisions**

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

**Integration of CARA in Drug Management Program**

* *Proposed rule:* CMS is proposing to integrate provisions of CARA (limit beneficiaries to lock-in to single provider or pharmacy) in Drug Utilization Review (DUR) policy and the Overutilization Monitoring System (OMS).
* ***SCAN comments:*** SCAN supports this provision because itallows plan sponsors to better manage opioid overutilization. Additionally, integrating with DUR and OMS policy will be consistent with documenting point of service edit solutions that curb beneficiary opioid overutilization.

**Non-opioid Medications**

* *Proposed rule:* CMS is seeking feedback on not including benzodiazepines, muscle relaxants, or other non-opioid controlled substances at this time.
* ***SCAN comments:*** SCAN supports not including such drugs on the list of frequently abused drugs at this time because the processes to control the frequent abuse of opioids should be tested first before expanding to other drug classes.

**Clinical Guidelines for Drug Management Program**

* *Proposed rule:* CMS is proposing that the 2019 clinical guidelines for drug management programs are based on the 2018 OMS criteria. These guidelines focus on populations who may be abusing opioids or receiving their drugs from multiple providers or pharmacies. More specifically, it includes the use of opioids with an average daily Morphine Milligram Equivalent (greater than or equal to 90 mg for any duration during the most recent six months) and EITHER four or more opioid prescribers and four or more opioids dispensing pharmacies OR six or more opioid prescribers, regardless of number of pharmacies.
* ***SCAN comments:*** While plans do generally stay consistent with the guidelines, SCAN supports giving plans flexibility in developing their own criteria to best serve their members (e.g., excluding certain populations in which the plan deems appropriate, such as those receiving end-of-life or palliative care).

**Grouping Prescribers**

* *Proposed rule:* CMS is proposing that, under clinical guidelines, prescribers associated with the same Tax Identification Number (TIN) be counted as a single prescriber.
* **SCAN comments:** SCAN generally favors this proposed change. However, SCAN systems do not have the capability of utilizing the TIN to group multiple prescribers from a single practice as one. Therefore, we recommend that CMS make this data available to help systems identify physicians in the same practice.

**Prescriber Agreement**

* *Proposed rule:* CMS is proposing that before a sponsor can limit the access of an at-risk beneficiary to coverage for frequently abused drugs, the sponsor must first obtain prescribers’ agreement of frequently abused drugs, unless the prescribers were not responsive to the required case management.
* ***SCAN comments:*** SCAN supports the general practice of obtaining prescribers’ agreement of frequently abused drugs prior to limiting access to coverage. The ultimate responsibility to limit access to frequently abused drugs to a beneficiary resides with the plan and should allow for exceptions to requiring prescribers’ agreement (e.g., when there is clear evidence of opioid overuse that could result in opioid-related harm and/or suspected fraudulent prescribing by a given prescriber).

**Exempted Beneficiary**

* *Proposed rule:* Beneficiaries in hospice and long-term care facilities who have a cancer doctor or who the Secretary elects to treat as an exempt individual are exempted from drug management programs.
* ***SCAN comments:*** SCAN supports cancer as an appropriate exemption. Further, SCAN believes that individuals receiving end-of-life and palliative care should also be specifically exempted from these programs, given their health status.

**Special Requirement to Limit Access to Coverage of Frequently Abused Drugs to Selected Prescribers**

* *Proposed rule:* CMS is proposing that a sponsor may not limit an at-risk beneficiary's access to coverage of frequently abused drugs to a selected prescriber until at least six months has passed from the date the beneficiary is first identified as a potential at-risk beneficiary.
* ***SCAN comments:*** While SCAN agrees that several approaches should be taken to resolve overuse, we feel that prescriber lock-in should not be restricted to implementation until six months after identification. Plans should have the authority to address instances where fraud, waste, or abuse is clearly evident. Prescriber lock-in would be an effective tool to quickly limit and resolve inappropriate use.

**Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries**

* *Proposed rule*: CMS is proposing to change the current continuous SEP rules to allow dual eligible only one annual opportunity to change plans. It would allow an additional opportunity to change plans if either a beneficiary is auto-enrolled in a plan and decides to change within two months, or if the beneficiary experiences a change in Medicaid or LIS status.
* ***SCAN comments:*** To preserve beneficiary choice,SCAN recommends keeping the continuous SEP for the dual eligible members or, at a minimum, providing a continuous SEP option that allows eligible beneficiaries to enroll into FIDE SNPs or comparably integrated products throughout the year.

**Any Willing Pharmacy Standards Terms and Conditions and Better Define Pharmacy Types**

* *Proposed rule:*CMS is soliciting comments on not expecting Part D plan sponsors to limit dispensing of certain drugs or drugs for certain disease states (e.g., specialty tier drugs) to a subset of network pharmacies, except when necessary to meet FDA-mandated limited dispensing requirements.
* ***SCAN comments:*** SCAN recommends allowing the creation of an evidence-based specialty-pharmacy network consistent with the member-outcome data that improves member medication adherence. Beyond merely meeting a price standard, specialty pharmacy networks can improve patient outcomes through consistent best practice. Plans should have the authority to tailor pharmacy networks with quality standards as a benchmark.

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

* *Proposed rule:* CMS is proposing to make conforming and technical changes to the outpatient days’ supply and long-term care transition days’ supply to a month supply.
* ***SCAN comments:*** SCAN supports allowing flexibility in the definition of a one month supply of medications (e.g., prepackaged 28-day supply medications versus 30-day supply for all medications) and reducing the long-term care transition supply to 30 days. This will help reduce waste and cost.

**Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes**

* *Proposed rule:* CMS is proposing to allow sponsors to immediately substitute new-to-market generics for brand products if there was no chance to do so during the bid and update process. CMS solicits feedback on whether and under what conditions immediate substitution should be allowed, even if a sponsor could have done so earlier.
* **SCAN comment:** SCAN supports this proposal and recommends the immediate substitution of the multi-source brand product with A-rated generic once A-rated generic becomes available on the market so that members have access to lower cost generics sooner.

**Treatment of Follow-On Biological Products as Generics for Non-LIS Catastrophic & LIS Cost Sharing**

* *Proposed rule:* CMS is proposing to define a generic drug to include a follow-on biologic. This applies only for purposes of cost-sharing for low income subsidy (LIS) beneficiaries and non-LIS beneficiaries in the catastrophic phase.
* ***SCAN comment:*** To improve enrollee incentives to choose follow-on biological products over more expensive reference biological products and reduce costs to both Part D enrollees and the Part D program, SCAN recommends including follow-on biological products (biosimilars) into the definition of the "applicable drugs" that are subject to the Coverage Gap Discount Program requirement from the manufacturer.

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

* Proposed rule: CMS suggests requiring plans to pass through to beneficiaries at the point of sale (POS) some or all of negotiated drug rebates and pharmacy incentive payments, which are now used to reduce premiums and overall cost-sharing.
* **SCAN comments:** SCAN strongly opposes this proposal. It would not accomplish the goal of reducing member out-of-pocket costs, but instead would cause premiums and cost sharing to rise significantly. Under current rules, pharmacy benefit managers (PBM) are able to use manufacturer rebates to lower drug costs for all members, not just members who take the drug that is being rebated. That will end under this proposal. Further, it will undermine PBMs’ leverage to negotiate the best price, as pharma companies reverse engineer rebates at the point of sale to gain awareness of their rivals’ pricing policy. It will undermine other areas of the drug benefit, including how drugs are tiered on formularies and preferred pharmacy networks. Finally, it will be extraordinarily difficult to administer. At a time when health plans need better tools to reduce drug prices, this proposal would discourage manufacturer competition and lead to high costs for beneficiaries and taxpayers. We suggest that CMS not pursue this proposal.

**Part D Payment Redeterminations and Independent Review Entity (IRE) Reconsiderations**

* *Proposed rule:* CMS is proposing to lengthen the timeframe for issuing decisions on payment redeterminations and IRE reconsiderations from seven to 14 days.
* ***SCAN comments:*** SCAN appreciates the extension of the existing timeframe for adjudicating enrollee payment appeal requests at the redetermination level in an effort to reduce burden on sponsors. Providing additional time to adjudicate payment requests will assist plans in limiting unnecessary denials and avoiding delays that could potentially cause beneficiary harm. Increased use of electronic health records and other technology will make information needed from prescribers more accessible, especially outside of business hours. We recommend that CMS continue to review potential regulatory changes that would permit Part D plans to extend the adjudication timeframe for certain coverage determination requests for drugs subject to prior authorization or step therapy, where the plan has been unable to obtain needed clinical information from the prescriber and the adjudication timeframe has been impacted by a weekend or holiday.

**Part D Preclusion Lists for Physicians and Eligible Professionals**

* *Proposed rule*: CMS is proposing to delete the Part D Prescriber enrollment requirement and create a preclusion list, which includes “demonstrably problematic prescribers.”
* ***SCAN comments:*** SCAN supports the proposal of rejecting the pharmacy claim for a Part D drug if the individual who prescribed the drug is included on the “preclusion list.” This would be defined in §423.100 and would include certain prescribers who are currently revoked from the Medicare program under §424.535 and are under an active reenrollment bar, or have engaged in behavior for which CMS could have revoked the prescriber to the extent applicable if he or she had been enrolled in Medicare. SCAN opposes the provisional supply requirements and proposes treating providers on the "preclusion list" similarly to the providers on the Office of Inspector General exclusion list where the provisional supply requirements do not apply.

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

* *Proposed rule:* CMS is proposing to significantly reduce the amount of MLR data that MA organizations and Part D sponsors submit to CMS on an annual basis. Under the proposed rule, MA and Part D sponsors would only report the MLR percentage and amount of any remittance owed to CMS for each contract. CMS would also revise the MLR calculation to include MLR numerator expenditures related to fraud prevention and clarify that compliant Medication Therapy Management (MTM) programs can be included in the numerator.
* ***SCAN comments****:* SCAN strongly supports the inclusion of fraud prevention expenditures in incurred claims for MLR reporting purposes. Including fraud, waste, and abuse expenses in the MLR calculation, rather than treating them as administrative costs, would encourage health plans to field more robust fraud detection programs and avoid efforts to pare back those activities. SCAN also supports the inclusion of MTM program expenditures in the MLR because doing so would encourage greater emphasis on the MTM programs, improve patient quality, and help reduce costs, allowing us to further strengthen and expand our MTM program.

In conclusion, SCAN appreciates CMS’s ongoing efforts to improve Medicare Part C and Part D on behalf of the millions of older Americans who rely on these programs. We believe that, with this proposed rule, CMS has put forth a number of proposals which would add much greater flexibility to Medicare Advantage, allowing plans to tailor benefits to patient needs and, in so doing, improve their lives.

We thank you for considering our comments, and look forward to working with you in the future. Please do not hesitate to contact us if we can provide further information.

Sincerely,



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