

August 31, 2022

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicare Program; Requests for Information on Medicare [Medicare Advantage]

Document ID Number CMS 2022-16463

To Whom It May Concern:

The ERISA Industry Committee (“ERIC”) is pleased to submit the following comments in response to the Request for Information (“RFI”) regarding improvements to the Medicare program, specifically concerning the Medicare Advantage program. ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under national, uniform standards, rather than a patchwork of different and conflicting state and local laws, in addition to federal law.

Americans engage with an ERIC member company many times a day, such as when they drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage or snack, use cosmetics, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, or go shopping.

ERIC member companies provide comprehensive health care and retirement benefits to millions of active and retired workers and their families across the country. Our members offer these great benefits to attract and retain employees to be competitive for human capital, to improve health – physical, mental, and financial health – and to provide peace of mind.

On average, ERIC large employer members pay around 85 percent of health care costs on behalf of their beneficiaries – that would be a gold or platinum plan if bought on an Exchange. These plans are self-insured, meaning that ultimately it is the company that is on the hook for the vast majority of the costs of our patients’ care. Self-insured employers abiding by the Employee Retirement Income Security Act of 1974 (ERISA) act as fiduciaries, ensuring that plan dollars are well spent, vendors are well managed, and patient data is protected, among many other responsibilities.

ERIC member companies are subject to other federal laws, including Medicare rules. ERIC members are keenly interested in the ongoing promulgation and enforcement of rules relating to these laws in order to maximize compliance, minimize unnecessary costs and burdens, and ensure optimal health outcomes for the millions of beneficiaries ERIC companies insure. Prior to COVID-19, there were an estimated 181 million Americans who received health care through their job, with about 110 million of them in self-insured plans.

Employers like ERIC member companies roll up their sleeves to improve how health care is delivered to communities across the country. They do this by developing value-driven plan designs and coordinated care programs, implementing employee wellness programs, providing transparency tools, and adopting a myriad of other innovations that improve quality and value, while making health care more affordable for patients.

Many ERIC member companies continue to offer high quality health benefits for retirees, with a particular emphasis on Medicare Advantage (MA) offerings. As such, ERIC has a vested interest in ensuring that the MA program continues to thrive and improve, and our member companies have a number of thoughts and comments on the program.

While we do not address every question posed in the RFI, our responses to specific questions are based on our members' current experience, benefits knowledge and expertise, and market factors.

Employers Care About Medicare Eligible Employees and Offer Them Extensive Health Care Coverage

Many ERIC member companies are significantly invested in benefits provided through the MA market, and voluntarily offer medical coverage to their Medicare-eligible retirees. These arrangements frequently involve employer group waiver plans (EGWPs) – established through direct contracts with CMS or, more commonly, through contracts with sponsors of Medicare Advantage and/or Medicare Part D plans. Other member companies provide retirees with stand-alone health reimbursement arrangements (HRAs) linked to Medicare exchanges, where beneficiaries get to pick their own Medicare plans with an employer subsidy. Contracting with MA plan sponsors allow employers to shift administrative responsibilities and insurance risk, thereby reducing long-term financial liabilities and lowering costs for retirees, while simultaneously saving significant amounts of money for CMS and taxpayers. While these plan sponsors choose different structures within the MA program, MA plans provide comprehensive, affordable, coordinated, and high-value coverage to over 29 million Medicare beneficiaries who, on average, are older, sicker, and more racially and ethnically diverse than enrollees in the traditional Fee-For-Service Medicare (FFS) program.¹

¹ "Quality, Health, and Spending in Medicare Advantage and Traditional Medicare". May 6, 2021
<https://www.ajmc.com/view/quality-health-and-spending-in-medicare-advantage-and-traditional-medicare>

In many cases, ERIC member companies offer retiree medical coverage that exceeds coverage provided under more traditional retiree medical plans or basic Medicare plans. As a result, employer-sponsored retiree health benefits produce high levels of beneficiary satisfaction.² ERIC member companies see the value in offering MA over FFS Medicare because it often delivers better services, better access to care, and better value for enrollees. **As plan sponsors, our members strive to provide the best health benefits possible to their employees, retirees, and families at an affordable cost, and the Centers for Medicare and Medicaid Services (CMS) can better support the stability of the program and value of MA plans by working directly with employers, and continuing to focus on growth, value, and innovation.**

Advancing Health Equity

Data Collection

The COVID-19 pandemic brought to light the health inequities within the United States' health care system for specific ethnic and racial groups, those in rural areas, the LGBTQIA+ community, and more. **ERIC applauds CMS for its work in developing proposals to advance health equity in MA, and encourages the continuation of existing policies that support health equity. In addition, ERIC believes that CMS should ensure that patients and plan sponsors have access to meaningful provider quality and safety information, as the information can be used to help patients make informed medical decisions, and help plan sponsors build better care networks.**

CMS can address this by expanding the availability of quality ratings in its Hospital Quality Programs, and by making sure hospitals collect and report on the appropriate patient data. The proper collection of disaggregated data sets is critical to reduce disparities and advance health equity in MA and across CMS quality programs. We understand that hospitals are not yet uniformly doing the important work of collecting disaggregated sociodemographic data or accurately stratifying quality and outcomes measures by social determinants of health. Importantly, complete data sets are critical to be able to accurately stratify quality measures. **ERIC encourages CMS to consider requiring all hospitals to collect disaggregated data by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status and immediately adopt and endorse The Office of the National Coordinator for Health Information Technology's 2015 Edition standards for collecting disaggregated data for all hospitals and for all CMS quality programs.** This will help to address the equity gap present in MA and all CMS programs.

² "Spotlight on Medicare Advantage: An eHealth Survey". June 2022.

https://news.ehealthinsurance.com/_ir/68/20225/Spotlight_On_Medicare_Advantage_eHealth_Survey_June2022.pdf

Supplemental Benefits

ERIC also recommends CMS support the expansion of supplemental benefits to best address patients' needs. Supplemental benefits are a main differentiator between MA and FFS Medicare, as MA can offer additional benefits that are “primarily health related” and specifically target benefits for the chronically ill that traditional Medicare cannot offer. This includes coverage for vision, hearing, telehealth, transportation, in-home support services, and much more. In a recent Milliman study, the firm found that plans annually increase their supplemental benefits offerings.³ These supplemental benefits are an added value for beneficiaries and lead to MA’s high beneficiary satisfaction. Supporting the expansion of supplemental benefits will help members receive the care that they need when and where they need it. Technologies such as telehealth platforms and new in-home care are examples of supplemental benefits that recently evolved or were approved. **We encourage CMS to be aware of and evaluate new technologies and services that benefit patients, which should be considered as eligible MA supplemental benefits.**

New technologies and services are constantly created and evaluated within the U.S. health care system. Digital health technologies like wearable devices provide an opportunity for individuals to become more aware of health factors, track progress toward health goals, and live healthier lives. They can help improve the treatment and prevention of chronic conditions and empower individuals with information they need to advocate for certain health care services.

Digital health care technology solutions also give payers and providers the opportunity to operate more efficiently and effectively.⁴ Health care technology companies offer innovative services for employers to provide them with a global view of the activity trends in their populations, and additional tools to help implement wearable devices as a part of their wellness programs. Employers strive to promote participation in employee wellness programs. Many employers currently offer a wearable device to employees free of charge, to improve health outcomes and connect health data to electronic medical records, providing an attractive option for many patients that also improves health and provides actionable information for plan sponsors. Any employer that currently wants to arm its employee population with a wearable device has to impute income to the employee equal to the value of the device, because the device itself is not a health benefit that can be excluded from income. We understand that Medicare limits reimbursement for certain medical devices such as wearables, and that reimbursement can take an extended period of time. Currently, MA plans may choose to buy and give wearable devices to enrollees similar to extra benefits currently offered like gym memberships and Meals on Wheels that are treated as supplemental benefits. **ERIC encourages CMS to allow wearable medical devices to be covered through the core medical benefit of both traditional Medicare and MA plans, so patients' health can be improved.**

³ “Overview of Medicare Advantage Supplemental Health Care Benefits and Review of Contract Year 2022 Offerings”. Milliman. https://bettermedicarealliance.org/wp-content/uploads/2022/03/MA-Supplemental-Benefits-Milliman-Brief_20220216.pdf

⁴ Walmart, Safety Wearables Help Keep Associates Safe at Work. May 4, 2021, <https://corporate.walmart.com/newsroom/2021/05/04/safety-wearables-help-keep-associates-safe-at-work>

If CMS leads by example, Congress will hopefully follow suit in addressing wearable medical devices and allowing employers to provide these medical devices to employees without imputing income (and thus giving rise to income taxes).

ERIC also encourages The Center for Medicare & Medicaid Innovation (CMMI) to test the expansion of access to MA supplemental benefits by increasing the rebate percentages for plans offering Special Supplemental Benefits for Chronically Ill Enrollees (SSBCI), which may enable plans to go even further in addressing social determinants of health and health equity. Research has found that social determinants of health contribute to the stark and persistent chronic disease disparities in the United States among certain groups.⁵ Testing certain plans that expand SSBCI and altering the rebate percentage can help the United States understand how best to address health equity and improve patient outcomes.

Chronic Kidney Disease

Following passage of the *21st Century Cures Act*, patients with kidney disease became eligible to enroll in MA plans, rather than FFS. About 37 million Americans are estimated to have chronic kidney disease that can eventually lead to end-stage renal disease (ESRD).⁶ Under the Medicare Secondary Payer Act, employers are committed to our obligations for ESRD patients and are prohibited from terminating coverage, imposing benefit limitations, or charging higher premiums based on the individual's ESRD. Most ESRD patients receive dialysis in a hospital at either two of the largest dialysis companies' locations or at home. **Because dialysis can be offered at a variety of locations, ERIC urges CMS to modernize the Conditions for Coverage (CFC) for ESRD facilities to keep pace with innovations in self-care, home dialysis, and telehealth for dialysis patients, remove barriers and streamline regulations for home-focused providers to expand patient access to home dialysis and self-dialysis, and promote access to care through alternative delivery sites.** Allowing more flexibility for the provisioning of care to ESRD patients will promote competition, increase access, and address the health care needs of vulnerable populations. **ERIC also implores the Administration to complete its rulemaking related to third-party payment of beneficiary premiums (particularly related to kidney dialysis patients), and to ensure that private sector MA plans are protected the same way as ACA plans will be protected — from abusive steerage of beneficiaries by dialysis companies and their charities.**

⁵ Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. *Annu Rev Public Health*. 2011;32:381-398. doi:10.1146/annurev-publhealth-031210-101218

⁶ Centers for Disease Control and Prevention. Chronic Kidney Disease Basics. February 28, 2022. <https://www.cdc.gov/kidneydisease/basics.html>

Expand Access - Coverage and Care

Prior Authorization

CMS each year receives comments from multiple stakeholders on reimbursement rates for providers in its Medicare program. While improper payment rates for Medicare services do occur, the Government Accountability Office (GAO) identified prior authorization as a critical tool to address the issue of improper payments made to providers.⁷ Employers believe that medical management is critical to controlling cost and improving quality for our plan beneficiaries. As ERISA fiduciaries, it is incumbent upon the employer to ensure that money is not wasted, that the network is not bloated with low-value or high-cost providers, and that plans are designed in such a way as to be good stewards of beneficiaries' funds.

Medical management techniques such as prior authorization, “try-first” requirements, step-therapy, and the like, while sometimes unpopular with patients, are absolutely integral to performing our fiduciary duties. Medical management processes – and the processes to make exceptions to them – are designed by medical experts not only to protect all beneficiaries from higher costs, but also to drive quality, limit patient exposure to riskier treatments, improve utilization of best practices, and often to encourage the use of safer and less invasive interventions. Employers know that beneficiaries would prefer to have immediate access to any treatment, medication, or care that they would like instantly – and that providers may prefer to develop a care plan without the input of the plan fiduciaries. However, this is not in the best interest of the beneficiaries or the plan. **We implore CMS to hold a dialogue with employers and employer groups about the value of prior authorization in the delivery of value-based care to MA beneficiaries, so that MA continues to deliver high-quality care and value to patients.**

Any limitations CMS considers on prior authorization in Medicare and MA, must be paired with reforms that protect patients, providers, plan sponsors, and the taxpayers. For instance, it is critical that a provider bypassing medical management have no financial conflicts that incentivize choosing one therapy over another. Providers should be required to utilize real-time benefit tools so that they can evaluate the costs and potential substitution products when prescribing. Additionally, when a formulary promotes more affordable (but clinically similar) options, the burden should be on providers to meaningfully justify bypassing medical management, which is designed to protect all patients, including MA beneficiaries, from dangerous services and avoid waste.

Telemedicine

Early on in the pandemic, the Biden Administration and Congress quickly realized that unnecessary barriers to telehealth would be a major problem for Medicare and MA beneficiaries. Many of these individuals were quarantined or in areas undergoing lockdowns. Many were in different states and regions that were experiencing peaks in hospital and provider capacity.

⁷ Government Accountability Office. “Medicare Program & Improper Payments”
<https://www.gao.gov/highrisk/medicare-program-improper-payments>

Medicare's own coverage of telehealth was nowhere near broad enough to replace much of the care that would otherwise be foregone due to medical facilities being closed to non-COVID patients.

The Administration and Congress acted quickly and decisively:

- CMS promptly eliminated state licensure barriers, allowing a willing and qualified provider to see a willing Medicare/MA patient via telehealth, without regard to their locations;
- CMS promptly eliminated state telehealth barriers for Medicare and MA, such as requirements that patients travel to specific originating sites before they can access telehealth, limitations related to modality (video-only requirements, etc.), requirements that the provider and patient have a preexisting relationship, and more; and
- CMS expanded Medicare and MA coverage to include more services for more patients, covered via telehealth.

These changes improved telehealth benefits for Medicare beneficiaries on a vast scale, instantly unleashing telehealth's tremendous potential to fill the voids created by the pandemic and paving the way for improvement. Unfortunately, very few changes in law have so far been made for individuals in the private sector not covered by Medicare and MA, despite employer efforts to expand and improve telehealth benefits. **While ERIC is pleased that Medicare and MA beneficiaries have updated telehealth policies, we continue to urge Congress to allow the same policies to apply to the rest of our employees and their families, so they may also benefit.**

ERIC also recommends that CMS allow audio-only telehealth visits as valid encounters for the documentation of diagnosis codes used for the calculation of MA risk scores. Such guidance is consistent with CMS' decision to allow audio-only telehealth for 90 FFS Medicare services and to designate certain audio-only services as valid for data submission under the Affordable Care Act (ACA). ERIC believes that the terms "telehealth" and "telemedicine" broadly include all types of care that use technology to connect a provider in one location and a patient in a different location. While some Medicare and MA beneficiaries may be more technology savvy than others, allowing audio-only telehealth benefits should be considered one of many options of utilizing telehealth.

Drive Innovation to Promote Person-Centered Care

Reimbursement and Value Based Care Arrangements

Employers value different Medicare reimbursement models, but find that Medicare Advantage better supports value-based arrangements that allow providers to take on more risk. Many large employers are participating in innovative initiatives to lower costs and improve care, such as direct contracting, high-performance networks, and centers of excellence.

ERIC member companies support the goal to increasingly transition to paying for value and outcomes rather than for the volume of services, promoting high-quality care while reducing unnecessary or duplicative services through the alignment of financial incentives.

ERIC member companies across many different industries and regions have set up and invested in innovative accountable care organization (ACO) arrangements with integrated hospital systems that focus on delivering coordinated, high-quality, and intensive primary care. These arrangements require provider partners to accept up and down-side risk, and to meet meaningful financial, quality, and patient satisfaction metrics. These arrangements can prove fairly difficult for small and medium-sized employers that lack sufficient employee volume to effectively negotiate with health systems exercising significant market power. Those smaller employers will need avenues by which they can combine beneficiary populations to achieve the value and significant change in the health of their employees from controlling blood pressure to managing diabetes. **One proactive step that CMS could take would be to urge providers who participate in value-based reimbursement models via Medicare Advantage, to extend similar options to their private sector payers.**

Some member companies have invested in direct primary care arrangements in areas where the health care market is not conducive to certain preferred provider partnerships like ACOs. In this model, member companies directly contract with health care providers that focus on population health and disease prevention. Some direct contracting programs have been in place since 2008 and continue to thrive in improving patient outcomes and lowering health care costs. States have also taken interest in direct contracting, such as Washington State, which established its program in 2009 but has since ended it. **Although CMS is winding down its Geographic Direct Contracting model and transitioning the Professional and Global Direct Contracting Model, ERIC encourages CMMI to continue with its Accountable Care Organization Realizing Equity, Access and Community Health (ACO REACH) Model to further increase value-based care arrangements in Medicare and MA.**

ERIC also urges CMS to consider ways to encourage comprehensive medication management (CMM) for Medicare beneficiaries, including those in MA plans. CMS should ensure that there are sufficient codes and protocols to reimburse clinical pharmacists for performing CMM, should incentivize MA plans to include this benefit for patients, and should consider updating quality measurement programs and tools to capture and reward those providers and plans that best utilize CMM techniques.

Centers of Excellence and Demonstration Projects

ERIC member companies also offer centers of excellence programs through which employees, those in MA and those who are not, can receive care for certain conditions at high-quality sites of care. The member companies often cover all procedures and travel costs (including for a companion), which encourages participation, but still saves significant money by improving quality of care and outcomes. ERIC member companies find value in offering this benefit to their employees, knowing that they are safe receiving care at a trusted facility. These centers of excellence raise quality throughout the health system by encouraging competition based on quality.

ERIC believes that Medicare should implement centers of excellence – either gradually starting with demonstration programs, or immediately based on already available data – so that Medicare beneficiaries can also have access to improved specialized care. Medicare should then publish all relevant data on quality and outcomes for the public. Further, participation in these centers of excellence should also be open to other payers beyond CMS.

While ERIC believes that improvements to the Medicare program will benefit all patients (due to systemic improvements that will take place throughout the health care system), employers are also seeking a more direct partnership with CMS in efforts to improve quality, reduce costs, and reform the payment system. Specifically, employers have watched with interest as CMMI tests various payment and service delivery models that aim to achieve better care for patients, smarter spending, and healthier communities. **ERIC would like CMMI to design and implement demonstration projects in a way that allows other payers, including large employers, to be active and full participants.** We define “participate” as actively setting up and abiding by the requirements of the demonstration and taking part in providing the required data, such that private plan beneficiaries can experience the same health care improvements that a participating Medicare beneficiary would experience, and private payers can utilize the findings and outcomes data to better hone our benefits design, network-building, and vendor management. Employer-sponsored MA plans would perhaps be the easiest way to begin to merge efforts between public and private payers in some of these innovative demonstration programs.

Support Affordability and Sustainability

Site Neutral Payments

ERIC is currently working to implement guardrails to protect all patients from unethical medical billing practices on Capitol Hill. In the past five years, there have been vast consolidation in health care markets, including mass purchase of provider practices by hospital systems. These purchases are often immediately followed by price inflation, including the addition of facility fees, as if the service was provided at the hospital, even though the care took place at a doctor’s office. This wasteful spending does not benefit the patient, and serves only to enrich entrenched medical interests. We are advocating to Congress that facilities be required to bill private payers using the appropriate forms, and unique site identifiers, so that inappropriate facility fees cannot be charged for visits to doctors’ offices or other offsite care as well as support the transition of site-neutral payments.

Medicare beneficiaries are experiencing this as well, and CMS can address the issue immediately for patients. CMS could further expand its site-neutral payment policies as outlined in the June 2022 MedPAC report and by aligning payment for office visits across ambulatory care settings, which would reduce program costs and beneficiary outlays. This action would ensure that MA patients are protected, while also protecting critical MA funds.

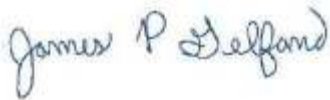
Engage Partners

The ERISA Industry Committee wishes to work closely with CMS on MA policy and welcomes an open dialogue to ensure that our MA plans are responsive to each of the communities the programs serve. We believe that new policies and improvements can be made through collaboration and team work, and look forward to hearing from you on how best we can support the MA program.

Conclusion

Thank you in advance for considering these comments. Please do not hesitate to contact me at 202-627-1922 or jgelfand@erc.org with any questions, or if ERIC can serve as a resource on the value of Medicare Advantage for employers and their workers.

Sincerely,



James Gelfand
President