

March 7, 2022



Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

LeadingAge appreciates the opportunity to comment on the Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage (MA) Program and Medicare Prescription Drug Benefit Program (“proposed rule”).

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging and disability services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

Our comments reflect the perspective of providers of post-acute care, long-term services and supports, and home and community-based services who contract with Medicare Advantage and Special Needs Plans to provide services. In addition, we also have providers who lead the operations of their own MA plans, Special Needs Plans (SNP) and PACE programs. Our comments will focus on issues with potential impact on their ability to effectively deliver services and be paid for those services.

Calculation of Maximum Out of Pocket (MOOP) Costs

Overall LeadingAge supports CMS’s proposal to begin requiring all Dual-SNPs (D-SNPs) to include cost sharing paid by Medicaid agencies and other third parties in the MOOP calculation though we share the concerns expressed about the potential negative impact to the Medicare Trust Fund of the additional Medicare spending. On the positive side, this change offers more parity for those providers, such as our member nursing homes and home health agencies, who may serve a disproportionately dual population. It could have the effect of providers receiving a full payment versus needing to track down the cost sharing amounts for extended periods of time for duals, as is the case today, when this cost sharing is not included in the MOOP by some plans. Given the significant reductions in payment that providers have suffered under recent contracts with the plans, any change to increase the reimbursement going to providers is appreciated. Having said that, we would be remiss if we didn’t note our concern about the potential impacts of this change including: 1) the projected increase in Medicare spending and its effect on the solvency of the Medicare Trust Fund; and 2) the potential negative consequence it might have of reducing available rebate dollars to the plans thereby limiting their ability to provide supplemental benefits. Nonetheless, these are costs that would otherwise have been born by

the D-SNPs, if the individual was not a dual eligible, and so the change really just requires all plans to behave similarly and reflects the true costs instead of cost shifting to Medicaid.

DSNP Integration and other changes.

LeadingAge applauds the CMS's efforts to adapt lessons learned from the Medicare-Medicaid Plans (MMPs) and apply them more broadly to D-SNPs continuing movement toward a more robust integrated experience for dual eligibles enrolled in D-SNP plans. In particular, we support the clarifications that better delineate financially integrated dual eligible (FIDE) and highly integrated dual eligible (HIDE) SNPs; the new requirement for Enrollee Advisory Committees, and efforts to ensure D-SNP quality stands alone.

LeadingAge has long advocated for an integrated approach to care and services delivery for older adults, dual eligible and those with chronic conditions. We see the potential that true integration-- both administrative and clinical. Individuals don't think of their care and service needs as Medicare or Medicaid but instead these are critical needs that help them remain independent and manage their health and daily activities. We agree a critical first step is that there is geographic alignment between the Medicare services area with that of the integrated D-SNP. It is just common sense. We support and appreciate the new proposed definitions for FIDE and HIDE SNPs as this creates a greater and more understandable distinction between the two types of integration by establishing that FIDE SNPs must: 1) include a full range of Medicaid covered services by requiring behavioral health, home health and durable medical equipment to be part of the required services beginning in 2025; 2) cover Medicare cost sharing as part of their Medicaid contracts; 3) must have exclusively aligned enrollment; and be solely for full-benefit duals. It was never clear to us how a plan could be fully integrated if it didn't have exclusively aligned enrollment. We also support that for current plans unable to achieve this level of integration that there is still a HIDE SNP option. Although ultimately, we think beneficiaries would do better in a FIDE model where a single organization is responsible for both the Medicare and the Medicaid benefit, and capitates for all LTSS and behavioral health services, and cost sharing. From a provider perspective, there will likely be a lower administrative burden when contracting with FIDE SNPs given the ability to submit a single claim for a dual eligible for all of their services and cost sharing. From a beneficiary perspective, these distinctions between FIDE and HIDE make it easier for them to understand their Medicare coverage options.

We also support the proposal to give states the authority to establish contracts with exclusively aligned plans and limiting those contracts to one or more D-SNPs. We agree that one of the added benefits of this approach is that the star ratings exclusively reflect D-SNP performance versus being co-mingled with other products under the same contract. Should states adopt this approach, it could provide a glimpse into the quality that duals are receiving from their D-SNP plans and may provide insights into whether we are measuring them on the right outcomes and whether individual products' quality should be distinctly reported instead of rolled up by contract. Given the unique needs of the dual eligible population, we wonder if further consideration should be given to comparing D-SNP performance exclusively to other D-SNPs (peer grouping) when assessing star ratings and/or if the quality measures used currently should be reviewed to determine their appropriateness for a dual population and whether different or additional measures should be considered.

Finally, on this section related to new requirements for D-SNPs, we support the addition of an Enrollee Advisory Committee requirement for D-SNPs but hope that either through regulation or sub-regulatory

guidance that CMS will provide a more specific framework for how D-SNPs can meet this requirement. For example, we think it would be helpful to specify a minimum number of participants and meetings of the enrollee advisory committee to ensure that it is meaningful. We also recommend CMS consider other required feedback mechanisms for enrollee input beyond just the proposed committee structure, which could have a limited number of participants or may not include those who have voiced concerns to or about the plan. We also encourage CMS to consider whether there may be additional state and federal policy benefits to compiling the findings of these Enrollee Advisory Committees. The aggregate information gained from these committees may be able to inform future policy direction at the national level for not only MA and SNPs but also for the fee-for-service Medicare program.

Standardizing Housing, Food Insecurity and Transportation question on HRA

LeadingAge supports the inclusion of one or more social determinants of health (SDOH) questions on housing, transportation, and food in all SNPs health risk assessments. We believe their inclusion will help these core issues to be identified sooner and addressed within an individual's care plan. There are benefits to collecting this information including trending data, which is noted in the proposed rule. However, we suggest CMS consider further revisions to the MA/SNP regulations to allow plans to use this SDOH data for determining eligibility for special supplemental benefits for the chronically ill (SSBCI) in their plans' offerings.

In response to the inquiry about whether questions on housing insecurity are relevant for enrollees who reside in congregate housing, we think they are equally important for this population as they are for those who reside in single-family homes. While some individuals may benefit from government assistance to help them remain in a congregate living setting, not all do. In fact, many, upon moving into such a setting, may spend down their resources over time threatening their ability to remain. Therefore, we believe it would be helpful to understand if an individual's current housing arrangements are precarious. Are they running out of resources and if so, by knowing this, could a plan be developed to connect these individuals to available resources such as applying for Medicaid or other housing assistance to help them continue to age in place? Alternatively, if plans understand that someone's finances are dwindling, they may also be able to connect them with other assistance or resources to slow that spend such as help paying for prescription drugs.

We think the example questions contained in the proposed rule provide a good starting point for the subsequent sub-regulatory guidance. However, we offer some additional questions for your consideration. On the subject of housing, [research](#) has shown that low income older adults who spend much more than they can afford on housing costs spend much less on health care and food than their peers who are not burdened by their housing costs. In addition, an inability to freely navigate one's home can hinder one's ability to perform activities of daily living and increase one's fall risk leading to accessing more costly care and services. For these reasons, we would suggest CMS consider revising its sample housing question to include the following additional or modified responses in its sub-regulatory guidance as we believe these responses will elicit more useful information that can then be addressed in an individual care plan:

Housing. What is your living situation today?

Please check all that apply:

- I have a steady place to live
- I pay more than I can afford for my housing
- I can move freely around the place where I live
- I do not feel safe in my neighborhood.
- I have a place to live today, but I am worried about losing it in the future.
- I do not have a steady place to live (e.g., I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park, etc.)

- **Food.** We support the example questions from the proposed rule but also offer a few additional, potential questions to consider as part of sub-regulatory guidance regarding food access:
 - Are you able to leave your home to shop for food?
 - Do you consistently experience any of the following barriers to accessing food?
(Check all that apply)
 - No or unreliable Transportation
 - Mobility issues making it difficult to get to a store and/or navigate a store once there
 - No store near me with healthy food options (e.g., fresh produce, meats, dairy, eggs)
 - No, I do not have these barriers.

- **Transportation.** While we think the example transportation question is a good start, we think it might benefit from some further refinement. For example, it would be helpful to understand if the lack of transportation is persistent vs. an infrequent occurrence (e.g., a family member was ill and couldn't take them to an appointment). It might also be helpful to understand the individual's main source of transportation including family/friend/neighbor, public transportation (bus, train, light rail, metro, taxi, or app-based ride service), personal vehicle. The mode of transportation could inform the plan if the person needs a provider who is on a bus or metro line, provide a sense of reliability of the transportation (e.g., bus only runs certain hours limiting when person can access services, etc.) and if the enrollee or someone else is responsible for getting them where they need to go, which could impact their ability to attend medical appointments.

We look forward to the information that these questions will yield and how it can be used to shape future plan benefits and develop strong individualized care and service plans for the enrollee. However, we also believe it is important that SNPs do more than just obtain answers to questions. They should also have a responsibility to use this information to assist their enrollees in identifying resources to address these unmet SDOH needs. We are not suggesting that the plan itself must directly deliver the

needed service but should help in connecting their enrollees with resources to help address identified needs. It is not clear if the proposed regulations imply that this should occur, but we would suggest CMS clearly describe the plan's role and responsibility related to information obtained through these questions. We encourage CMS to track this standardized data to identify trends and perhaps compare to supplemental benefits offered and utilized. Are enrollees accessing available plan benefits that would address their SDOH needs?

Network adequacy

We appreciate the proposal that would permit CMS, beginning in contract year 2024, to deny an application for a new or expanded service area if the plan fails to demonstrate compliance with network adequacy standards for the new or expanded area(s). We think the proposed approach that gives a plan a 10 percent credit off the network adequacy standards through the application review process is reasonable especially given the expectation that the plan must be in full compliance without the 10-percentage point credit at the start of the plan contract year. What is not clear is what happens if the plan does not achieve the full network adequacy requirements by the time the plan year begins? CMS can't deny the contract at that point or remove the new or expansion areas because this would be disruptive to those already enrolled in the plan. However, without teeth to the regulation, what would incentivize a plan to ensure compliance with the established network adequacy standard? We hope CMS will consider the consequences of a plan's failure to achieve network adequacy, in general, but also for the new and expanded area applications, especially in light of the fact that plans already received several accommodations on meeting network adequacy requirements in recent years (e.g., non-urban time and distance standards at 85% instead of 90%).

We also support CMS's proposal to consult states when a plan submits a request for a network exception, as the state can offer a key understanding of the on-the-ground dynamics regarding availability of providers or other relevant factors that may result in a better decision on these exception requests.

Expanding factors to deny contract expansions

LeadingAge supports the additional proposed factors for which CMS can deny an MA/SNP plan application including plans with 2.5 stars or fewer quality rating, bankruptcy or filing for bankruptcy, or too many compliance actions beyond an established threshold. These are good first steps. We would like to see CMS take stronger action against plans with numerous and persistent compliance actions, or consumer/provider complaints.

Minimum Loss Ratio reporting requirements

LeadingAge agrees with CMS's proposal to reinstate the more detailed MLR reporting that had been in effect from 2014 to 2017 with the proposed rule's addition of incurred claims for supplemental benefits. We see many benefits accruing from the information obtained from this reporting including useful information on how much utilization there is of the various categories of supplemental benefits such as primarily-health related, non-primarily health related and special supplemental benefits for the chronically ill (SSBCI). This is an important first step in understanding what value beneficiaries receive from these offerings. Ideally, we would like to see this information at a more granular level to understand which specific benefits are being utilized to inform future Medicare and Medicare Advantage policies. We recognize for plans to report on a per supplemental benefit level would require additional standardization of supplemental benefit categories within the application process. While this

standardization could be beneficial in one sense, it could also have an opposite impact of stifling innovative benefit packages.

Oversight of Marketing and Communications

CMS reported it has seen more than a doubling of complaints related to marketing between 2020 and 2021 with many complaints related to Third Party Marketing organizations (TPMOs). Therefore, to combat these issues, CMS is proposing 3 new requirements related to marketing and communications: 1) TPMOs must include a standard disclaimer noting that not all available plans may be available via the TPMO; 2) plans must ensure the TPMO compliance with requirements; 3) Plan/TPMO contracts must disclose any subcontracted relationships for marketing and enrollment.

LeadingAge members have also heard a number of marketing complaints from the older adults they serve regarding the marketing behavior of some Medicare Advantage and Special Needs Plans. For examples, in one state, a TPMO or plan sent letters to older adults that look as if the person was already enrolled in the plan and asked the person to complete certain information and return it. The recipient of the letter completes the form that looks required only to find out later that they are now enrolled in a new MA plan. Given the situations we've heard, we are supportive of efforts to make marketing communications from that TPMOs along with MA/SNP plans clearer and minimize these tactics from bad actors. In addition, to the proposed changes related to TPMOs, we hope CMS will consider additional regulation or guidance requiring TPMOs to also disclose that they work for one or more insurance plan(s) and are not independent like a State Health Insurance Assistance Program. Transparency not trickery should be required when educating and enrolling beneficiaries. Alternatively, CMS might consider seeking additional funding to support State Health Insurance Assistance Programs to ensure unbiased assistance to all Medicare beneficiaries and their families and/or expanded promotion of the availability of these programs.

Clarifying Requirements on Access to Care During Disasters and Emergencies

We greatly appreciate CMS proposals to make the application of section 422.100(m) more clear. We, too, have observed and experienced the ambiguity in the applicability of section 422.100(m) during the current national Public Health Emergency (PHE). One particular area of concern our provider members have encountered is the interplay when there is a both a declared national or public health emergency, and a state emergency. In these situations, plans and providers alike are uncertain if the special requirements under section 422.100(m) apply when one ends and one continues.

We see that CMS's proposed changes amend the current regulations by adding a second criteria – "disruption in access to health care" -- that must be met for the special requirements for access to non-contracted providers to be triggered. While this narrows the application of the special requirements, this additional caveat seems to address the real issue which is enrollee access to care. In addition, CMS appears to be taking a broad view of what constitutes "disruption in access to health care" going beyond just physical barriers. Based upon the CMS narrative on this provision, we believe this would include staffing shortages that limit access to contracted beds, such as has occurred during COVID-19 pandemic. We also appreciate that that "disruption in access to health care" includes language about plans inability "to meet the normal prevailing patterns of community health care delivery in the service area." CMS notes that "prevailing patterns" refers to a pre-disaster or pre-emergency standard not the current pattern in an emergency. This is a helpful and important clarification.

We also think the clarification that the special requirements are in effect for a 30-day minimum period is helpful, but we have concerns about the effects on beneficiaries. CMS discusses this 30-day period of applicability as a transitional period but seems to imply that a plan could require an enrollee to switch from receiving services or treatment from a non-contracted provider to a contracted provider during this timeframe. We would urge caution permitting plans to require a beneficiary to transition from an existing provider to another provider solely because they are in-network. We ask that CMS clarify whether there are other beneficiary protections currently in regulation to protect against this potential disruption in care or ask that CMS add language to ensure such a beneficiary protection. We know how important continuity of care is to a patient's success and recovery so changing providers midstream may be disruptive and actually lead to complications or extending the individual's need for services. We ask that CMS consider the need for continuity of care as part of these transitions.

We believe the proposed changes address issues our members have encountered and share a recent situation to test our understanding of how we believe the proposed changes would apply to a circumstance encountered by providers in one area of Michigan. In this case, network SNFs were closed to admissions either due to COVID outbreaks in the SNF or inability to sufficiently staff open beds. Nonetheless one plan refused to permit enrollees to receive services from non-network SNFs in the area who had available beds. The result was a backlog of older adults in area hospitals at a time where beds were also needed for COVID patients. The plan's position was that since the state's emergency declaration was no longer in effect that it was not required to comply with 422.100(m). It would appear that the proposed regulations would alleviate this confusion because: 1) the national emergency still applied; 2) there was a "disruption in access to health care" exists where "the prevailing patterns of community health care delivery in the service area" were not being met and 3) given 1 & 2, the special requirements would be triggered for plans in this service area. We would appreciate if you could confirm that our application of the proposed changes is correct.

Assuming we have appropriately interpreted the proposed changes related to special requirements, we are in support of these amendments to 422.100(m). We suggest three other areas CMS might consider developing additional guidance on whether through additional regulatory language, sub-regulatory guidance, or public information resources:

- Mechanisms to ensure transparency for beneficiaries and providers about when these special requirements are in effect. For example, could CMS publish a list of areas under special requirements or another transparent way for beneficiaries and providers to understand when these rules must be followed. This could conceivably be important to beneficiaries seeking recourse under an appeals and grievances process should access to care be denied.
- Whether special requirements should apply in other situations beyond national or state emergencies such as shortage of health care staff or in cases where provider contracts are not renewed. Neither of these examples may rise to the level of a state or national emergency but they may still impact normal patterns of community health care delivery and as a result, impact enrollee access to care warranting expanding the pool of providers.
- How non-contracted providers are to be paid by the MA/SNP when the special requirements are triggered. This issue appears unaddressed by the current and proposed regulations. It would be helpful if CMS clarified at what rate a non-contracted provider must be paid. We would suggest Medicare FFS rates for the services provided given that no contract is in place

and most contracted providers are receiving 60-80% of Medicare fee-for-service rates. While we seek this additional clarification, we support maintaining an enrollee's in-network cost sharing obligations in these circumstances.

Request for Information Regarding Prior Authorizations

In the proposed rule, CMS seeks feedback on how prior authorizations worked during the public health emergency related to plans being given the flexibilities to stop prior authorization requirements for patient transfers, wait times for receiving a response for when prior authorizations are in place.

LeadingAge's Skilled Nursing Facilities (SNFs) had a similar experience to what was documented in the narrative of the proposed rule. Our providers appreciated the flexibilities afforded MA/SNP plans to address the situation on the ground especially in the earliest days of the Public Health Emergency (PHE). Initially, we were pleased to witness Medicare Advantage Organizations (MAOs) taking full advantage of the flexibilities offered under the PHE in 2020 ensuring access to not only traditional Medicare services but also rethinking the delivery of supplemental benefits. In one area of the country, we are pleased to report a group of plans authorized grocery delivery services to ensure community-dwelling, frail beneficiaries were able to minimize their exposure to COVID-19 in the early months of the pandemic. However, as the pandemic has worn on, we have seen and heard that many plans have returned to current laws and regulations reinstating prior authorizations and refusing use of non-contracted providers under section 422.100(m) even though access issues have remained or fluctuated throughout the PHE. Not all of the situations we share here are related to prior authorizations, but we include them to be illustrative of what our provider members have seen occur during the PHE related to the flexibilities permitted by CMS:

- In New York in the second half of 2020, we were contacted by SNF providers who had a short-stay rehabilitation resident who was told by the plan they no longer required SNF care and needed to be discharged even though there was not a sufficient place to discharge the individual to. The resident was still COVID positive, and their family was either unwilling or unable to have them return home where they may infect other family members. Yet the plan was still insisting on the discharge.
- In Michigan, we have heard multiple stories where a combination of staffing shortages and/or COVID outbreaks have reduced the number of available post-acute care skilled nursing facility beds in a community/service area. The impact is area hospitals have a backlog of patients who can be discharged but have no appropriate place to discharge them to. Clearly, post-acute care availability fluctuates daily. This inability to transfer the patient to a SNF, in turn, reduces the number of available hospital beds in the community for new admissions. MA enrollees may have more limited options as hospitals must transfer them only to a contracted SNF that may not have an available bed. Patients shouldn't have to wait to receive needed services because there isn't a contracted SNF bed available when a non-contracted provider is able to accept the admission. This situation affects Medicare FFS and Medicare Advantage patients alike but an FFS patient would be allowed to move into any available bed. The MA plans in the area have offered no indication that they can use the PHE flexibilities to remedy the situation. Others have indicated that since the state emergency declaration has ended that the special requirements no longer apply even though the national PHE remains in effect. Certainly, the proposed

changes to section 422.100(m) contained within the proposed rules will help resolve the current ambiguity about when the special requirements apply in the latter situation.

- We have heard that one of the major national plans initially eliminated the need for prior authorizations but did so on a month-by-month basis. In November 2020, we got word that from this same state that, “people are stacking up in the hospital because the plans aren’t approving prior authorizations for SNF care.”

In addition to pandemic times, we often hear from our provider members throughout the country of their frustrations how prior authorizations work under MA/SNP plans under the course of regular business. In some locations around the U.S., prior authorizations for SNF services can take as long as 20-30 days. By the time the decision is made, the SNF services have started and ended. In the meantime, the SNF was required to inform the enrollee that if they choose to access the SNF care recommended by their discharging physician at the hospital, the MA plan may not pay, and the enrollee would be financially responsible for the full cost of services received. This is not the type of stress beneficiaries need when they have recently been discharged from a hospital and require additional skilled care services.

We believe that if MA plans opt to use utilization management tools such as prior authorization, then they should staff those divisions adequately to meet the caseload that they themselves create. We ask CMS to consider amending the MA regulations to include a section that establishes reasonable timeframes by which plans must issue these utilization management determinations (e.g., prior authorizations) and establishes some consequences or penalties for failure to meet these timelines. CMS could establish language that if a plan fails to approve a prior authorization within a certain number of days established by the HHS Secretary, then services would be automatically approved for a minimum number of days or visits as appropriate to the urgency and type of service. Alternatively, the HHS Secretary could establish timely prior authorization requirements for plans and if a plan fails to make a timely decision, perhaps they are required to pre-pay providers for similar services for the next 6 months when prior authorizations are pending. In addition, CMS might consider tracking prior authorization decisions as part of star rating system such as, what is the typical decision timeframe for a prior authorization? How many prior authorizations are approved and how many denied compared to requested? How many are appealed? And of those appealed, how many are overturned? This might provide useful information in determining whether these administrative burden for these requests is warranted. This is a time-consuming process for providers and the question is whether they make a difference at all.

In addition to prior authorization and other utilization management decisions not being made timely, the 2018 [OIG report](#) indicates when decisions are being made, they are not always correct. The report notes that 75% of prior authorization denials are overturned by the plan upon appeal and CMS cited 56% of audited contracts for making inappropriate denials. These data would suggest changes need to be made to these processes. The report also agrees that penalties and sanctions aren’t working, “CMS took enforcement actions against MAOs, including issuing penalties and imposing sanctions. Because CMS continues to see the same types of violations in its audits of different MAOs every year, however, more action is needed to address these critical issues.” For these reasons, we encourage CMS to take a broader approach to any future regulations regarding prior authorizations and other utilization

management tools as there are concerns not only with how these processes work in a public health emergency as well as under normal circumstances.

Coordination of Supplemental Benefits

We strongly support efforts to integrate Medicaid and Medicare services for dual eligible especially when it simplifies or clarifies the payer of the service and eases access for the beneficiary. As CMS and the states further contemplate the coordination between traditional Medicare and Medicaid benefits and the supplemental benefits that plans offer, we encourage them to remember that non-medical and special supplemental benefits for the chronically ill (SSBCI) supplemental benefit offerings are still relatively new and as such, plans are still making changes from year to year. Therefore, supplemental benefits should probably not be a substitute for Medicaid coverage but instead use them as a wrap-around benefit building a more comprehensive or robust package of services and supports. Many of the supplemental benefits offered are limited in scope compared to the same benefit under Medicaid. For example, an enrollee might be eligible for up to \$2500 in in-home care benefits for the plan year compared to a more comprehensive benefit under Medicaid that is based off their assessed needs. It For integrated D-SNPs, it might make sense for the state to take a more active role as the plan designs its supplemental benefit package.

Medicare-Medicaid Plans

LeadingAge supports CMS's direction in the proposed rules to simplify D-SNP and integrated plans. We understand if the proposed D-SNP changes are finalized that CMS will seek to work with states to transition Medicare-Medicaid Plans into the integrated DSNP rubric. We agree that simplifying the number of products offered to duals would be easier for states to administer as well as beneficiaries and providers to understand. However, we would caution CMS to carefully evaluate the aspects of MMPs that may be lost such as the integrated enrollment process and integrated beneficiary communication materials. We would also encourage CMS to consider how it might maintain the options counseling it provides as part of the current MMP program and consider expanding its use to all managed care products, as beneficiaries could benefit from a neutral source of information as they evaluate their FFS and MA/SNP choices.

Thank you again for the opportunity to share our thoughts with you regarding the future direction of Medicare Advantage and Special Needs Plan policies. We are happy to discuss or answer any questions you may have.

Sincerely,



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