

# BETTER MEDICARE

## ALLIANCE

March 4, 2016

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Acting Administrator Slavitt:

Better Medicare Alliance (BMA) is submitting this comment letter on the recently released 2017 Advance Notice and Call Letter on behalf of our alliance of nurses, doctors, plans, employers, retiree organizations, and beneficiaries who support Medicare Advantage (MA). BMA advocates for MA through education and information, commentary on policy, research on the evidence, and public engagement on behalf of our ally organizations and beneficiaries. BMA views MA as an important option within Medicare that offers affordable, high quality, integrated care for Medicare-eligible beneficiaries. MA's innovative, value-based, cost efficient payment model is consistent with the goals of the Administration. MA is leading the way towards a value-based health care model in Medicare and has ambitious goals set for risk-based payment agreements. MA is also a trusted and popular option for beneficiaries. The most recent enrollment data shows over 18 million individuals - 1/3 of all Medicare beneficiaries, have chosen MA. These beneficiaries value the affordability, simplicity, and care coordination available under MA and look for stability and continuity in coverage in the years ahead.

Below we detail concerns with several policies proposed in the 2017 Advance Notice and Call Letter and outline the key requests we are articulating on behalf of our alliance, including:

- *We ask the Centers for Medicare & Medicare Services (CMS) to promote stability in the MA program by limiting significant administrative and payment changes. Continual changes to the program create complexity and disruption for beneficiaries and providers, especially when implemented consecutively.*
- *We ask CMS to provide more robust impact analyses on proposed policies in order to encourage and enable stakeholders and the public to best assess the consequences of the policies and offer a complete response. Most importantly, more detailed analyses on potential beneficiary impacts, such as potential loss of benefits, increased cost sharing, and loss of plan access are requested.*
- *We strongly encourage CMS not to implement the proposal to change MA retiree coverage that would result in an estimated 2.5-2.8%<sup>1</sup> payment reduction to employer, government, and union retiree MA plans. This MA retiree coverage, officially known as Employer Group Waiver Plans (EGWPs), has unique attributes that warrant recognition in the methodology for payments. The proposal would have a disruptive effect on employers who count on this mechanism to provide continuity in benefits for their retirees as well as retirees who live on fixed incomes and depend on MA benefits.*

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<sup>1</sup> Employer Group Waiver Plans Financial Impact Based on the 2017 Advance Notice Summary. Milliman. (March 2, 2016).

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- *We ask CMS to ensure a stable risk adjustment system, more transparency in payment calculations, and a smooth transition to using encounter data as a diagnosis source. The change to encounter data increases provider burden and also needs more time to be tested and for best practices to be developed and shared. Moving from using 10% encounter data to 50% encounter data in just one year is too much too soon.*
- *We look forward to working with CMS to ensure that future changes to the Star Rating program successfully incentivize high quality care for all beneficiaries in all plans.*

Thank you for your thoughtful consideration of BMA's concerns and requests.

### Empower Stakeholders with Transparency and Analysis

As advocates for MA, we appreciate the in-depth work CMS has done in preparing the 2017 Advance Notice and Call Letter. BMA is committed to an evidence-based approach in our support of MA, and we find the analyses CMS provided in the proposed regulation useful. As we work towards providing better predictability and transparency for plans, providers, and beneficiaries, we appreciated the Fall release of the risk adjustment and Star Rating proposals. This additional time allowed for more analysis by stakeholders and public input. These efforts will be enhanced further next year due to the extended comment period and time between the Advance and Final regulations. Additional time will improve the quality of the analysis and comments that stakeholders will be able to provide to CMS about this important program.

However, more can be done to give stakeholders the tools they need to give meaningful feedback on the proposals to CMS. Providing more robust impact analyses on all policy proposals will make it easier for beneficiaries, clinicians, employer groups, and other stakeholders to weigh-in. For example, we have received feedback that the lack of a robust impact assessment for the MA retiree coverage proposal has made it more difficult for employers, governments, and unions to determine how the proposal will impact beneficiaries. More information also could have been included related to the early experiences of providers as they begin to implement the transition to encounter data. In addition, greater transparency in regards to actuarial calculations, such as MA Growth Rate and FFS Normalization methodologies, would enhance stakeholder understanding and feedback.

Most importantly, BMA calls on CMS to provide more information on how policy proposals impact beneficiaries – both prospective and retrospective analysis is helpful. Understanding the real-life impacts of policies on older adults and disabled individuals is paramount to BMA.

*We call on CMS to release the outstanding data and impact analyses for all 2017 proposals. It is important to our coalition, and to all stakeholders, to have this information in order to fully understand all proposed changes, assess the impact of those changes, and articulate the changes to constituents. We know CMS values productive feedback, particularly on policy proposals that could potentially destabilize the program and harm beneficiaries' access to benefits. More data and analysis will best enable these kinds of well-informed responses.*

### Protect Medicare Advantage Retiree Plans

The most important goal for BMA is to ensure that all Medicare beneficiaries, including retirees, have access to the high quality care offered in MA. MA continues to demonstrate that it is leading the way on value-based care and improved health outcomes. Research shows that MA

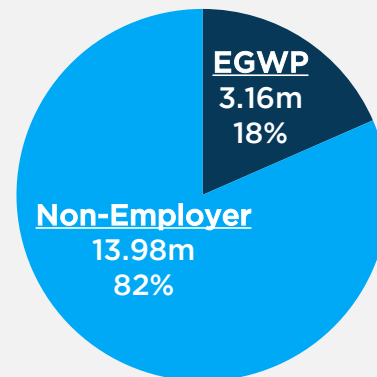
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delivers better care and improved outcomes for Medicare beneficiaries when compared to FFS Medicare.<sup>2,3,4,5</sup> Employers, governments, and unions recognize the quality of MA and increasingly choose to provide coverage to their retirees using MA retiree coverage. Between 2009 and 2016, MA retiree coverage enrollment grew 73%, from 1.82 million to 3.16 million.<sup>6</sup> This growth outpaced MA non-employer (non-EGWP) growth and total MA enrollment growth during the same time period – 64% and 65%, respectively.<sup>7</sup> Thus, we have serious concerns about CMS’s proposed changes to MA retiree coverage that will impact these retirees and their employers.

In the 2017 Advance Notice, CMS stated it believes that terminating the MA retiree coverage bid process will avoid cost and administrative burden and, “will facilitate the offering of Part C plans for employers and unions seeking to establish high quality coverage for their Medicare eligible retirees.”<sup>8</sup> However, our coalition, including employer groups, believes it will have the opposite effect and will reduce payment, create operational difficulties, and discourage these offerings. Although there was no impact analysis released with the proposal, experts estimate the proposed change could result in a significant 2.5-2.8% payment reduction to employer, government, and union retiree MA plans. These changes would result in a serious disruption in coverage and care for the 3.2 million retirees, which is 18% of all MA beneficiaries, who currently depend on these MA plans.<sup>9</sup> MA retiree coverage gives retirees access to high quality, affordable coverage and allows employers to deliver on their commitment to employees. Any action that limits access to MA is not desirable for employers, providers, or beneficiaries.

**Figure 1: Total MA Enrollment: MA Retiree Coverage (EGWP) vs. Non-Employer, February 2016**



Source: Avalere Health analysis using February CMS data.

Employers, including governments, industries, and unions, have turned to MA to provide a seamless transition from employee to retiree health insurance coverage for large groups. MA retiree coverage gives these employers the ability to continue coverage that offers the comprehensive, coordinated care their retirees expect, and in many cases have negotiated in labor contracts. Access to MA for these retirees enables them to access coverage with

<sup>2</sup> Sukyung Chung, Lenard I. Lesser, Diane S. Lauderdale, Nicole E. Johns, Latha P. Palaniappan and Harold S. Luft. Medicare Annual Preventive Care Visits: Use Increased Among Fee-For-Service Patients, But Many Do Not Participate. *Health Affairs*, 34, no.1 (2015):11-20.

<sup>3</sup> Landon, B.E., Zaslavsky, A.M., Saunders, R.C. Pawlson, G. et al., Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-2009, *Health Affairs*, 31:12 (2012).

<sup>4</sup> Basu, J., Mobley, L.R. Medicare Managed Care Plan Performance: A Comparison Across Hospitalization Types, *Medicare & Medicaid Research Review*, 2:1 (2012).

<sup>5</sup> Jeff Lemieux, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. Hospital Readmission Rates in Medicare Advantage Plans-*Am J Manag Care*, 18, no. 2 (2012):96-104.

<sup>6</sup> Avalere Health analysis using February 2016 CMS data. (Excludes Medicare-Medicaid dual-eligible demonstration plans, Cost, and PACE plan enrollment.)

<sup>7</sup> *Ibid.*

<sup>8</sup> CY2017 Advance Notice and Call Letter. The Center for Medicare & Medicaid Services. (February 19, 2016): 23.

<sup>9</sup> Avalere Health analysis using February 2016 CMS data. (Excludes Medicare-Medicaid dual-eligible demonstration plans, Cost, and PACE plan enrollment.)

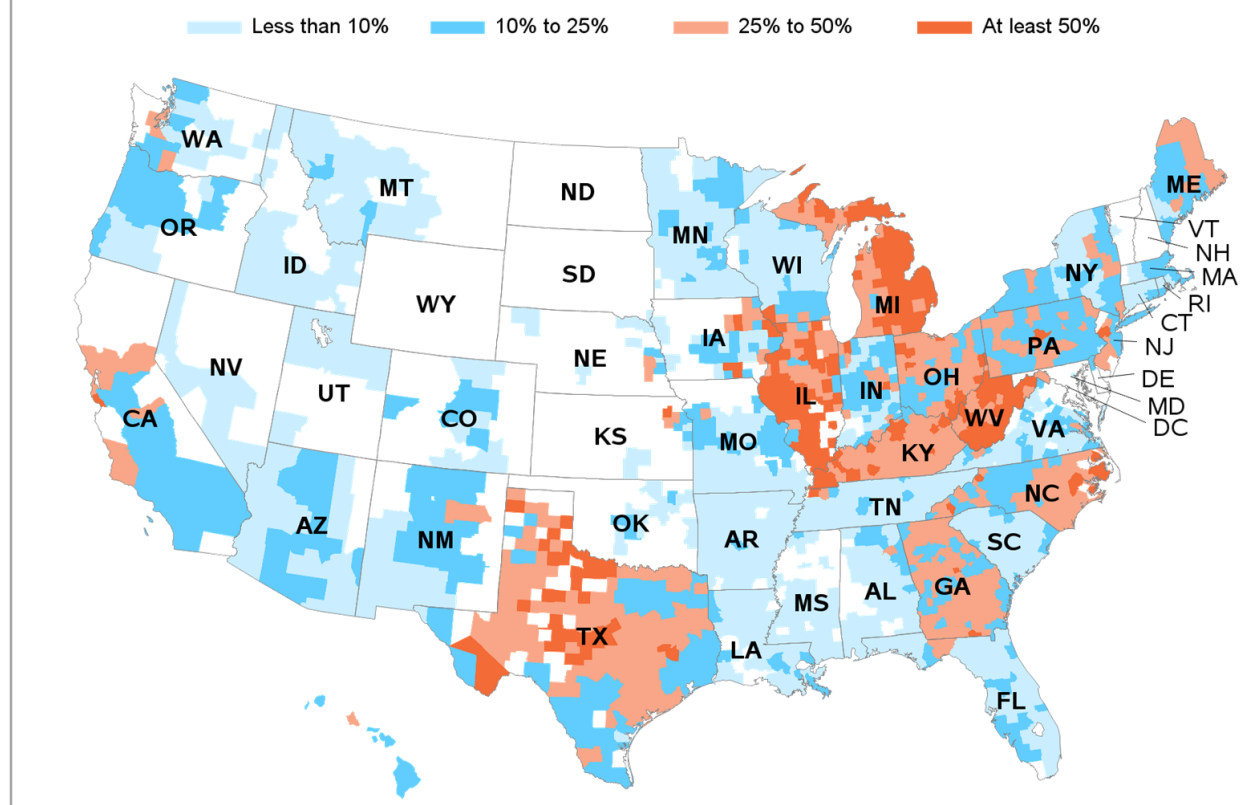
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enhanced benefits that more closely match their pre-retirement coverage. Specifically, unlike Traditional Fee-For-Service Medicare (FFS), MA provides important additional benefits and services to enrollees, such as vision, dental, hearing, in-home care, case management, and prescription drug management tools. Retirees in employer-sponsored MA plans also have cost protections that are not available in FFS, such as an annual cap on out-of-pocket costs and lower premiums. In fact, many MA beneficiaries have out-of-pocket maximums even lower than the cap – 56% have out-of-pocket costs lower than \$5,000.<sup>10</sup>

From New York to California, Michigan to Texas, millions of retirees are receiving better care through MA. In these four states alone, over 1.23 million retirees could have disruption in their care due to the proposed change to MA retiree coverage.<sup>11</sup>

**Figure 2: Percent of Total MA Enrollees in Retiree Coverage by County, February 2016**



Source: Avalere Health analysis of February 2016 enrollment data from CMS.

Ensuring continuity for millions of retirees across the country who depend on access to this superior care is important. In addition, as *Figure 2* illustrates, this disruption would have a disproportionate impact on certain states, counties, and cities. For example: 1 in 2 Michigan MA enrollees will be impacted by this proposal; 2 in 5 Illinois MA enrollees; and 1 in 4 MA enrollees in Ohio, North Carolina, and Georgia.<sup>12</sup>

<sup>10</sup> Pope, C. Supplemental Benefits Under Medicare Advantage, Health Affairs Blog (January 21, 2016). Available at: <http://healthaffairs.org/blog/2016/01/21/supplemental-benefits-under-medicare-advantage/>

<sup>11</sup> Avalere Health analysis using February 2016 CMS data.

<sup>12</sup> Ibid.

*We urge CMS not to implement this policy that would result in a reduction to MA retiree coverage and disrupt this value-based program. In addition, we ask CMS to provide an impact analysis to ensure beneficiaries fully understand how the MA retiree coverage proposal could impact their access to benefits.*

*Reconsider the Retiree Coverage Proposal Due to Unique Attributes of MA Employer Plans*

In CMS’s MA retiree coverage proposal, it outlines its conclusion that there is “no apparent rationale or explanation” for higher costs and bids for MA employer plans as compared to non-employer bids.<sup>13</sup> However, this is not the experience of our coalition. MA plans that provide coverage for employer, government, and union retirees have key distinctions from individual MA plans. These differences are dismissed in the proposed changes and warrant recognition in the methodology for payments. They include the fact that retirees are enrolled in groups rather than as individuals and these groups of retirees have contractual expectations that require compliance.

Additionally, coverage for retirees must cover much larger geographic areas than the MA individual market, and therefore require broad access to providers nationwide. As a result, MA retiree plans are more analogous to Local Preferred Provider Organizations (PPOs) than Health Maintenance Organizations (HMOs). However, the methodology CMS proposed would use an enrollment-weighted average of all non-employer plans as the proxy for MA retiree plans. This is concerning to BMA because 74% of non-employer enrollment is in HMOs and 15% is in Local PPOs, whereas in MA retiree coverage, 34% of enrollment is in HMOs and 65% is in Local PPOs.<sup>14</sup> (See *Table 1.*)

**Table 1: Percent of MA Enrollees by Plan Type, Non-Employer vs. MA Retiree Coverage (EGWP), February 2016**

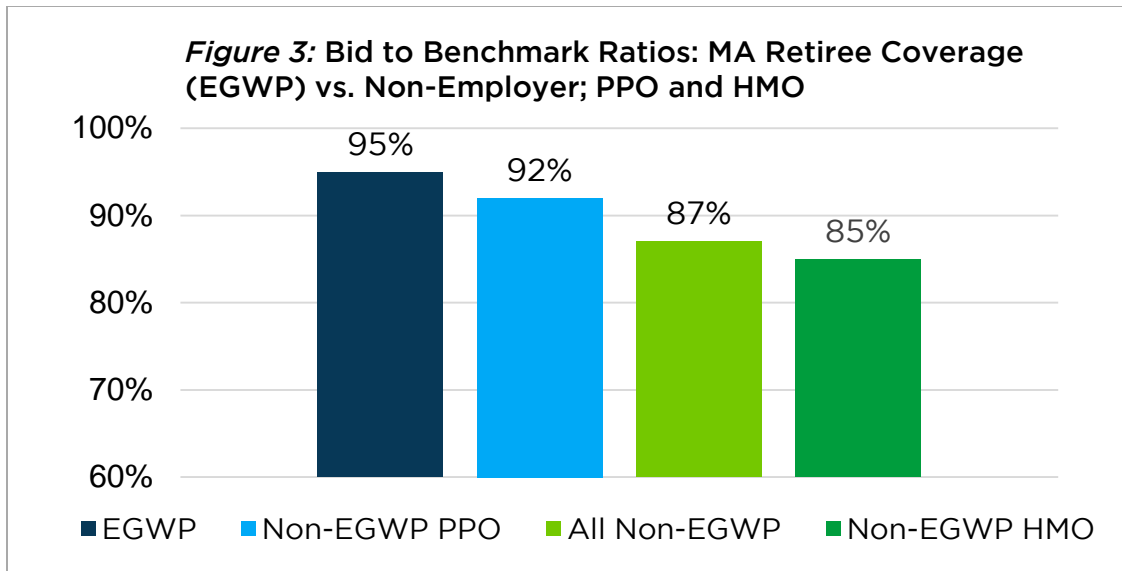
Plan Type	MA Non-Employer	MA EGWP	All
HMO	74%	34%	66%
Local PPO	15%	65%	24%
Regional PPO	9%	1%	8%
PFFS	2%	0%	1%
MSA	0%	0%	0%

Source: Avalere Health analysis of February 2016 enrollment data from CMS.

This large proportion of HMOs in the non-employer cohort skews the bid-to-benchmark ratio towards the HMO bids, which do not accurately represent bids for plans with large provider networks. When MA retiree coverage has a more appropriate comparison applied, to non-employer PPOs, the bid to benchmark ratios are comparable (see *Figure 3*).

<sup>13</sup> CY2017 MA Advance Notice. CMS. (February 19, 2016): 26.

<sup>14</sup> Avalere Health analysis of 2014 Medicare plan payment data and 2014 Ratebook from CMS.



Source: Avalere Health analysis of 2014 Medicare plan payment data and 2014 Ratebook from CMS.

This effect is also demonstrated at the state level. *Table 1* presents bid-to-benchmark data for the top 5 states by MA retiree plan enrollment – the MA retiree plan bid-to-benchmark and Local PPO bid-to-benchmark ratios track closely and the HMO ratios are much lower. Data at the County and Metropolitan Area level also illustrate this pattern – in fact, in four of the largest Metropolitan Areas, bid-to-benchmark ratios for MA retiree plans were less than Local PPO ratios.

**Table 2: MA Bid-to-Benchmark Ratios: MA Retiree Coverage (EGWP) vs. Non-Employer; PPO and HMO – Top 5 States by MA Retiree Coverage Enrollment**

State	Number of EGWP Enrollees, February 2016	EGWP/Total MA Enrollment in State	Individual Bid-to-Benchmark Ratio		EGWP Bid-to-Benchmark Ratio
			HMO Plans	Local PPO Plans	All MA Retiree Plans
California	509,619	22.8%	83.5%	97.8%	87.9%
Michigan	304,928	49.3%	90.0%	97.8%	99.2%
New York	216,599	17.6%	84.2%	92.3%	95.3%
Texas	200,878	17.6%	79.4%	88.8%	90.4%
Pennsylvania	200,569	19.7%	91.4%	92.4%	98.5%

Source: Avalere Health analysis of 2014 Medicare plan payment data and 2014 Ratebook and 2016 enrollment data from CMS.

*Due to the harmful implications of the proposed changes to MA retiree coverage and problems with the methodology, we ask that CMS reconsider the proposed changes to the payment calculation. We call on CMS to recognize the significant differences between employer-sponsored and non-employer plans.*

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### *Reconsider the EGWP Proposal Due to Disruption for Retirees and Employers*

When considering significant changes to MA retiree plan payments, CMS must be cognizant of the timing of any changes to the current methodology. Contractual obligations for retiree coverage can be multi-year rather than annual, so changes made in one year are especially difficult to implement. Currently, CMS is proposing to implement an entirely new payment system in a way that would cause disruption.

Experts estimate that the proposed termination of the bid system in favor of a fixed payment system could result in a 2.5-2.8% reduction in payment to MA retiree plans – and the impact could be greater in some regions.<sup>15</sup> This will likely reduce access to important benefits such as vision and dental, and increase costs for beneficiaries, including higher premiums and co-payments. The current proposal does not give employers or retirees adequate time to prepare for this major change. Contracts are already negotiated and planned for 2017.

*Should CMS decide to move ahead, adequate preparation time for employers is essential and CMS should take steps to ensure a smooth transition. This would include releasing a detailed impact analysis, implementing a phase-in period, and assisting employers in the transition. To this end, if CMS determines that this disruptive change should be implemented, it would be reasonable to delay the implementation to give employers time to prepare for the change.*

### Ensure Stability in Risk Adjustment and a Smooth Transition to Encounter Data

Accurate risk adjustment is essential to high value care in MA. It ensures all beneficiaries have access to all plans and it enables plans to have the resources required to meet the needs of beneficiaries. Accurate risk adjustment supports early intervention, coordinated care, and better outcomes for MA beneficiaries, especially individuals with complex chronic conditions. The need for stability in risk adjustment was recognized in this year's decision to continue to keep the coding adjustment increase constant. In addition, we support CMS's work to ensure adequate resources are available for individuals who are dually eligible for Medicare and Medicaid. However, we have concerns about the continually changing CMS-HCC Risk Adjustment Model. It is important for CMS to recognize that changes to the model are difficult for stakeholders, including clinicians, to understand, assess, and implement. These difficulties are amplified when CMS does not release information assessing the impacts, consequences, or concerns that resulted from previous changes before it implements new changes. For example, BMA is concerned that the Risk Adjustment proposal could have a negative impact on Institutional Special Needs Plans (I-SNPs); additional analysis on the impact of the proposal would help our coalition assess these concerns.

*Therefore, in light of the recent implementation of ICD-10 and move to the 2014 CMS-HCC Risk Adjustment Model, we ask that CMS phase-in any additional changes to the Risk Adjustment Model and release more information analyzing Risk Adjustment Model changes.*

We also have serious concerns about the proposal to dramatically accelerate the movement towards encounter data as a diagnosis source. The proposed change for 2017 to increase encounter data to 50% would significantly change the blend of the Risk Adjustment Processing System (RAPS) and the Encounter Data System (EDS). We have concerns that the EDS system,

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<sup>15</sup> Preliminary 2017 MA Rate Notice Analysis. Wells Fargo Securities. (February 22, 2016).

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as well as providers and plans, are not yet ready for this aggressive timeline – potentially resulting in less accurate risk scores. CMS has stated that it expects risk scores calculated using EDS to be similar to risk scores calculated using RAPS<sup>16</sup>. However, the filtering logic used within EDS, such as provider type and facility requirements, are different and we are concerned that this will result in risk scores that do not accurately capture beneficiary health status. In addition, because there has not been an impact assessment released that compares the two systems, it is difficult for stakeholders to understand the full impact of the change.

*We request that CMS continues to work with stakeholders, especially clinicians, to ensure the filtering logic effectively captures all diagnoses and accurately calculates risk scores.*

In addition, since EDS requires submission of procedures, supporting information, and all other claims-related information, in addition to diagnoses, it creates an additional burden on providers and plans. Providers continue to work to ensure that encounter data submissions are done accurately and bounce backs and other issues are resolved. Additionally, providers are training staff to properly submit data. These implementation activities create significant administrative burden, especially when considered with the recent change to ICD-10 and other pressures on the Risk Adjustment Model. It is important for CMS to recognize the difficult administrative and operational challenges related to implementation of EDS and ensure a gradual and stable transition. Moving from using 10% encounter data to 50% encounter data in just one year is too much too soon, especially without a robust impact analysis.

*We encourage CMS to provide an analysis of the potential impact the proposed EDS change will have on stakeholders and request a smooth and responsible transition to encounter data.*

### Better Align the Star Ratings Program with Value-Based Payment

It is vital to BMA that the Star Rating system effectively supports quality improvements for MA beneficiaries, including low income and disabled individuals. We recognize CMS's commitment to improving the current model for all beneficiaries. We continue to evaluate the Indirect Standardization interim adjustment proposal to ensure it does not result in lower quality standards for low income beneficiaries. However, we remain primarily focused on the long term goals of the Star Rating system, which are designed to require accountability and drive quality improvements. The Star Rating system must be committed to offering successful incentives for high quality care for all beneficiaries in all plans. Specifically, we think that moving to a Star Rating system that prospectively sets cut-point targets would better enable value-based contracting arrangements between providers and plans. The current retrospective system inhibits the potential of a value-based payment system. Knowing these targets in advance would result in better aligned quality incentives and higher quality for beneficiaries.

*In support of this goal, we will continue to encourage CMS to improve the Star Rating system in a way that encourages the Administration's goal of value-based contracting and delivery reform. We look forward to working with CMS and its Star Rating evaluation partners to support this work.*

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<sup>16</sup> CY2016 MA Final Announcement. CMS. (April 6, 2015): 35.



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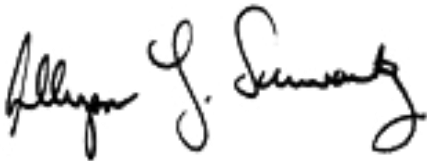
## Conclusion

As a coalition of 49 ally organizations and over 100,000 beneficiaries, BMA represents a wide range of stakeholders. Together we believe MA is leading the way on the path towards high quality, value-based care for all Medicare beneficiaries. MA is an incubator for innovation and reform that benefits MA enrollees and the entire Medicare system. The 2017 Final Announcement must support these goals of innovation, effectiveness, and improved health outcomes. It should prevent disruption in the MA model that is working for our allies, beneficiaries, and the Medicare system.

As you prepare the CY2017 Final Announcement, we urge you to ensure that finalized changes support the goals of providing coverage that enables early intervention, care coordination, and reduced disease progression. Should changes be made, such changes should be implemented in such a way that mitigates disruption to plans, providers, and beneficiaries.

We appreciate that CMS and the entire Administration recognize the value of MA and understand that its continued success depends on both stability and predictability. This commitment enables innovative and dynamic improvements in the delivery of care to 18 million beneficiaries. We look forward to continuing to work together towards our shared goals for the Medicare Advantage program and Medicare beneficiaries.

Sincerely,

A handwritten signature in black ink, reading "Allyson Y. Schwartz". The signature is written in a cursive style with a large, stylized initial 'A'.

Allyson Y. Schwartz  
President & CEO  
Better Medicare Alliance

## **Better Medicare Alliance Allies**

Aetna  
Alliance for Aging Research  
American Benefits Council  
American Association of Nurse Practitioners  
American Medical Group Association  
American Nurses Association  
American Osteopathic Association  
Association for Behavioral Health and Wellness  
Business Council of New York State  
Coalition of Texans with Disabilities  
Chamber of Commerce Southern New Jersey  
Commerce and Industry Association of New Jersey  
Denver Metro Chamber of Commerce  
Florida Health Networks  
Greater Philadelphia Business Coalition on Health  
Health Quality Partners  
Healthcare Leadership Council  
HealthSpan Partners  
Healthways  
Humana  
Indiana University Health  
International Council on Active Aging  
Iora Health  
Kentucky Teachers' Retirement System  
Mercy Health  
The Latino Coalition  
National Association of Manufacturers  
National Association of Nutrition and Aging Services Programs  
National Caucus and Center on Black Aging  
National Hispanic Coalition on Aging  
National Hispanic Medical Association  
National Medical Association  
National Minority Quality Forum  
National Retail Federation  
NaviHealth  
New Jersey Business and Industry Association  
New Jersey State Chamber of Commerce  
New Jersey State Nurses Association  
Nurse Practitioner's Association of New York State  
Palm Beach Area Agency on Aging  
Pennsylvania Chamber of Business and Industry  
Philadelphia Corporation for Aging  
Population Health Alliance  
SilverSneakers Fitness  
Society on Women's Health Research  
Texas Association of Business  
UnitedHealth Group  
U.S. Chamber of Commerce  
VSP Vision Care

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Better Medicare Alliance (BMA) is the leading coalition of nurses, doctors, health plans, employers, aging service agencies, advocates, retiree organizations, and beneficiaries supporting Medicare Advantage. Medicare Advantage offers quality, affordability and simplicity, with enhanced benefits to more than 17 million Medicare beneficiaries across America. BMA works to ensure the sustainability and stability of Medicare Advantage through information, research, education, and united support among stakeholders to strengthen this important coverage for seniors and people with disabilities.