America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

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Sean Cavanaugh, Deputy Administrator, Centers for Medicare & Medicaid Services, Director, Center for Medicare
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A., Director, Parts C & D Actuarial Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies and Draft CY 2017 Call Letter

Dear Mr. Cavanaugh and Ms. Lazio:

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies and Draft CY 2017 Call Letter.

Our members are strongly committed to serving Medicare beneficiaries under the Medicare Advantage and Part D programs, and our comments are designed to promote stability and high quality care for the beneficiaries they serve. More than 17 million Americans, or 31% of all Medicare beneficiaries, have chosen to enroll in the Medicare Advantage program. Medicare Advantage plans provide the model for population-based healthcare services and delivery system reform. They lead the way in advancing innovative, patient-centered programs that integrate and coordinate care, focus on prevention and early detection and support for individuals with chronic diseases, reduce beneficiary costs, and address the needs of low-income and other vulnerable individuals. A strong and stable Medicare Advantage program is critical to achieving national policy goals for an improved healthcare delivery system that includes expanded use of quality-based payments, continued innovation, and enhanced care coordination and disease management.

Yet several proposals from the Centers for Medicare & Medicaid Services (CMS) in the Advance Notice are inconsistent with those goals. A new report by Oliver Wyman concludes that the Advance Notice would cut funds from this high performing program by an average of 0.5 - 3.9%.[1] Enrollees in some plans would see significantly greater cuts. Proposals of significant concern include:

[1] Giese, Glenn, Sober, Josh, Fitzpatrick, Randall. "2017 Advance Notice: Changes to Medicare Advantage Payment Methodology and the Potential Effect on Medicare Advantage Organizations." Oliver Wyman. March 3, 2016.

- A new risk adjustment model that would have large negative impacts and exacerbate cuts implemented by CMS last year that target health plans' efforts to transform the healthcare system through early detection and prevention of chronic conditions;
- Increased use of diagnoses for risk adjustment via an unstable and not fully tested encounter data system; and
- Lower payments for employer and union-sponsored retiree health coverage.

The cuts would add to Affordable Care Act (ACA) funding reductions that continue to be phased-in for 2017 in one-third of the country. Moreover, the proposals build additional layers of complexity, uncertainty and unpredictability into Medicare Advantage. For these reasons, it is critical that CMS modify these proposals and others noted in our attached detailed comments to allow plans to continue innovating and working with providers on transforming the healthcare system, and to protect millions of seniors and individuals with disabilities who value the coordinated care and higher quality coverage they receive through Medicare Advantage.

The Value of Medicare Advantage

It is widely recognized that Medicare Advantage plans provide enrollees with a different approach to care delivery than beneficiaries in the original or fee-for service (FFS) Medicare program, which is built on an antiquated, uncoordinated 20th century model that still primarily pays providers for the volume of services rather than for high quality, cost effective care. Recent initiatives by the Department of Health and Human Services to expand a variety of Medicare Advantage practices into the FFS program such as risk-based payment and chronic care management, and the research highlighted below, demonstrate the importance of these programs.

- A study published in *Health Affairs* found mammography screening rates were over 13% higher, eye tests for individuals with diabetes were 17% higher, and cholesterol screening rates for individuals with diabetes and cardiovascular disease were 7 - 9% higher in Medicare Advantage plans compared to FFS.[2]

- Another study that appeared in the *American Journal of Managed Care* found the hospital readmission rate for Medicare Advantage enrollees was about 13% - 20% lower than for FFS enrollees.[3]

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[2] Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. al. "Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services in HMOs than in Traditional Medicare." *Health Affairs* 32. No. 1228-1235. July 2013.

[3] Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care* Vol. 18, no. 2, 96-104. February 2012. This study was preceded by a series of working papers and reports published by AHIP's Center for Policy and Research. One earlier study based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27% lower in Medicare

- Another *Health Affairs* study found beneficiaries with diabetes in a Medicare Advantage special needs plan had "seven percent more primary care physician office visits; nine percent lower hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare."[4]

- Independent research shows that Medicare Advantage plan practices have a positive "spillover" effect on FFS Medicare, which allows it to realize savings (such as lower hospital utilization) in areas with high Medicare Advantage plan penetration.[5]

Medicare Advantage beneficiaries report high levels of satisfaction with the program. A North Star Opinion Research survey found 90% of beneficiaries are satisfied with their plans, 94% are satisfied with the quality of care they receive, and 90% are satisfied with the benefits they receive in their Medicare Advantage plan.[6]

Critical Policy Concerns

As noted above, we have serious concerns that several policies in the Advance Notice would jeopardize the stability of the Medicare Advantage program for beneficiaries and inhibit the ability of health plans to continue making progress in care coordination and disease management innovation for more than 17 million seniors and individuals with disabilities enrolled in these plans. Our attached comments discuss these issues in detail and offer recommendations for changes needed to ensure stability and protect beneficiaries. Below we highlight several of these issues which are of utmost importance to Medicare Advantage plans.

A. Changes to the Medicare Advantage Risk Adjustment Model

AHIP strongly supports a risk adjustment model that more accurately predicts costs of care, including for Medicare Advantage plans focusing on beneficiaries who are dually eligible for Medicare and Medicaid and others with complex needs. Aligning the Medicare Advantage payment system with broader health policy goals allows for increased coordination of care, a reduction in unnecessary hospital readmissions, and other innovations demonstrated to improve the lives of beneficiaries. Unfortunately, the proposal in the Advance Notice to calculate non-

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Advantage than in FFS Medicare among patients with at least one admission. See: http://www.ahip.org/Hospital-Readmissions/.

[4] Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. al. "Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-09." *Health Affairs* 31. No. 12: 1-9. December 2012.

[5] Baicker, Katherine, Chernew, Michael, Robbins, Jacob. "The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization." *Journal of Health Economics* Vol 32 1289-1300. September 2013.

[6] North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."

institutionalized beneficiary risk scores separately depending upon "full dual eligibility status", "partial dual eligibility status", "non-dual eligibility status", and disability status, raises serious concerns:

- **Overall Medicare Advantage Funding Reduction.** CMS estimates that the proposed model would reduce overall funding to the Medicare Advantage program by 0.6%, or approximately $1 billion. We believe the Agency's estimate considerably understates the impact of the new model on Medicare Advantage plans. As discussed further in our detailed comments, we understand this estimate calculated the difference in risk scores under the two models at a particular point in time but did not specifically calculate the average impact on plan payments from 2016 to 2017. A new Oliver Wyman study finds a comparison on this basis means that the 2017 model is likely to reduce overall revenues to the Medicare Advantage program by 2.1%. Proposals reducing funding to the Medicare Advantage program have the potential to promote instability for the beneficiaries who depend upon our member plans to provide better care and improve outcomes compared to the FFS program.

- **Reduced Payments for Beneficiaries with Chronic Diseases.** For several years AHIP and its members have highlighted that the new Medicare Advantage risk adjustment system fully phased-in for 2016 — including changes that eliminated recognition of early stages of certain conditions — does not accurately predict costs for beneficiaries with chronic conditions and harms efforts to detect and treat chronic diseases at their earliest stages. A recent Avalere study confirms that the 2014 model under-predicts costs for individuals with multiple chronic conditions by $2.6 billion on an annual basis, and under-predicts costs for a number of specific chronic conditions.[7] The new model would worsen this situation by lowering coefficients assigned to conditions such as diabetes, congestive heart failure, and chronic obstructive pulmonary disease.

  As we have previously stated, CMS's changes to the risk adjustment system should be consistent with national health policy goals of early detection, treatment, and prevention of disease progression for chronic diseases. These Medicare Advantage plan activities provide the foundation for reforms put forward by Secretary Burwell to transform Medicare and have been demonstrated by recent studies to have positive spillover effects that are improving care and reducing costs throughout the program. Changes that further reduce coefficients for chronic diseases in the risk adjustment model are inconsistent with this goal.

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[7] Avalere Health. "Analysis of the Accuracy of the CMS-Hierarchical Condition Category Model." January 2016. Available at: http://go.avalere.com/acton/attachment/12909/f-028f/1/-/-/-/-/012016_Avalere_HCC_WhitePaper_LP_Final.pdf.

- **Data Quality Problems and Impact on Dual Eligibles.** We strongly oppose the proposal to identify dual eligibility status "concurrently" on a monthly basis during the payment year rather than continue the existing approach of measuring such status once during the prior year. Medicaid eligibility information from states, including data distinguishing full and partial dual eligibility, is often extremely unreliable. The likely data quality problems and significant delays in receiving information would introduce new levels of administrative cost, operational complexity (including retroactive changes), and uncertainty into Medicare Advantage that could deleteriously affect the contributions these plans make for the beneficiaries they serve.

- **Normalization Factors.** We have concerns about the calculation of the FFS normalization factors and, as indicated in the detailed comments, we recommend CMS consider alternative calculations that would more appropriately reflect trends in the Medicare program and protect beneficiaries.

Given the totality of these concerns, we believe CMS should not move forward with the 2017 model as is currently constructed. The Agency must ensure the risk adjustment model does not penalize beneficiaries enrolled in plans providing valuable services that research shows improve quality and beneficiary outcomes, or create additional costs, complexities and uncertainties for the Medicare Advantage program. AHIP and our member plans are committed to continuing to work with the Agency to improve the model.

B. Encounter Data

We have very serious concerns with CMS's proposal to increase — from 10% to 50% — the percentage of the risk score calculation based on encounter data. As CMS indicates, the Agency has been collecting encounter data from Medicare Advantage plans for several years. Plans have invested significant efforts in developing and testing systems and working with CMS to improve the process. However, our members have identified numerous unresolved operational, technical and other issues that continue to limit the ability of the encounter data system to capture the full stream of diagnoses and establish a data stream that is sufficiently reliable. In the attachment, we provide more detail about those issues and others relating to CMS's new filtering logic and the initial implementation of ICD-10 that have the potential to reduce the stability of the Medicare Advantage program for beneficiaries.

While CMS did not include an estimate of this impact in its fact sheet, the Oliver Wyman report suggests this could reduce funding to Medicare Advantage plan programs that promote better beneficiary outcomes by up to 3%. Given this impact and the fact CMS is under no statutory obligation to increase the use of encounter data, we strongly urge CMS not to adopt this proposal. CMS must not increase reliance on an unstable system that could have adverse impacts on a program relied on by so many vulnerable beneficiaries. No increase in the percentage of risk score

determined by encounter data should take place until this filtering logic has been vetted and tested by Medicare Advantage plans; its impacts are fully understood; and the system is stable and operational issues are resolved. AHIP and our member plans are committed to continuing to work with the Agency to improve the implementation of and reliance on encounter data.

C. Employer Group Waiver Plans (EGWPs)

Employers, including state and local governments along with union sponsors, use customized EGWP products to finance retiree coverage for almost 3.2 million beneficiaries, approximately 1 in 5 (18%) Medicare Advantage enrollees. AHIP is extremely concerned about the proposal in the Advance Notice to reduce EGWP rates beginning in 2017 by eliminating bids and paying plans based on payments to non-EGWP plans.

CMS did not estimate the impact of this proposal in its fact sheet. Oliver Wyman projects the proposal could reduce funding to EGWPs by 2.5 - 4.5%. CMS's proposal also raises serious operational issues. Payments to EGWPs are used by the employers and unions offering EGWPs to finance retiree coverage. However, under the proposal, employers and unions would not know the cost of offering coverage until after CMS calculates the weighted average bids of non-EGWPs, which the Agency recently indicated may not be until August prior to the payment year. This uncertainty could create significant disruptions for employer and union sponsors that would have long ago budgeted for health costs for the 2017 year and that need to know costs for purposes including establishing premium and cost sharing and developing beneficiary communications.

EGWPs provide individuals with a seamless transition to retiree coverage that often is consistent with benefits they received as active workers and can satisfy other priorities identified by union sponsors to serve their group health plan members. With over 3 million Medicare beneficiaries enrolled in EGWPs and in light of these impacts, we urge CMS to rescind this proposal.

D. Star Ratings Proposals

AHIP and our member plans continue to appreciate CMS's willingness to recognize the significant evidence of challenges under the Star Ratings System that are faced by plans focusing on low-income populations. Evidence of differential outcomes remains despite the considerable efforts our members are putting forward to meet the needs of their beneficiaries.

We remain concerned that the Agency's proposal to address this issue — the creation of a Categorical Adjustment Index (CAI) for a small subset of measures — would not provide meaningful help to plans serving beneficiaries with complex needs. Moreover, as proposed, there would be no such assistance until calendar year 2018. We also remain concerned with the complexity of the proposal and the potential for the CAI to have negative impacts on some plans despite their significant investments to ensure high quality care for their enrollees.

We understand that CMS views the proposal as an interim adjustment that would be taken pending a comprehensive review of socioeconomic status by measure stewards and the Office of the Assistant Secretary for Planning and Evaluation. Given the proposal's limited nature, complexities, and potential adverse impacts, we recommend: (1) a hold harmless be applied to ensure no plan is penalized under the approach; and (2) positive adjustments under the CAI be made available for plans in payment year 2017. Moreover, CMS should clearly state that the CAI is an interim adjustment and will not apply beyond payment year 2018, and the Agency will work with plans on developing a long term approach to these issues that incorporates findings from the additional studies noted above.

Detailed Comments

Our attached comments cover a range of areas, including but not limited to the issues identified above and issues specific to Part D. In addition, we welcome the Agency's willingness to focus on issues important to plans covering beneficiaries in Puerto Rico, and urge CMS to move forward in the Final Notice with an adjustment to reflect the larger proportion of FFS Medicare beneficiaries in Puerto Rico who have zero claims compared to other parts of the United States. We and the broader healthcare delivering system also raise concerns about the increasing benefit thresholds in Part D due to high cost prescription drugs and the potential adverse impacts for Medicare beneficiaries. Our goals are to ensure the Medicare Advantage program continues to place beneficiaries first by promoting stability and innovations to improve quality and transform the program.

However on balance, the significant cuts in the Advance Notice will threaten the stability of benefits for over 17 million seniors and individuals with disabilities, many of whom are low-income and have high healthcare needs. We urge CMS to issue a Final Notice on April 4 that maintains a strong and stable program and ensures plans can continue to provide innovative, high quality care for current and future beneficiaries.

We look forward to providing any additional information you may need and to continuing to work together to improve the health of the beneficiaries our members serve.

Sincerely,

Matthew Eyles
Executive Vice President
Policy and Regulatory Affairs

Mark Hamelburg
Senior Vice President
Federal Programs