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## **MARCH 3, 2017**

Dear Acting Director Tudor and Director Lazio:

Better Medicare Alliance (BMA) is submitting this comment letter on the 2018 Advance Notice and Draft Letter on behalf of our community of over 80 allies and hundreds of thousands of beneficiary advocates who all share a mission to build a healthy future by advocating for a strong Medicare Advantage. We appreciate that this Advance Notice and Draft Call Letter, as well as actions and public statements by CMS, offer recognition that Medicare Advantage is leading the way in modernizing health care delivery for Medicare beneficiaries. Medicare Advantage is driving the focus on quality, affordability, and care management in Medicare, particularly for individuals with multiple chronic conditions. Medicare Advantage plans, providers, and community partners are working to improve health outcomes and cost efficiency through innovative care delivery and patient engagement.

We believe that Medicare Advantage is an important part of the future of Medicare and we look forward to working with CMS and the Administration to ensure that Medicare Advantage is a strong, stable, and sustainable option for all beneficiaries in the years ahead.

Our comments and recommendations on the proposed changes in payment and policy for 2018 are detailed below. In summary, the key recommendations offered on behalf of our ally organizations and beneficiary advocates support Medicare Advantage through the following actions:

- **Reward quality by lifting the benchmark cap** on high quality 4-Star or higher plans.
- **Ensure stability in risk adjustment** by freezing the coding intensity adjustment at the statutory minimum and correcting the Normalization Factors.
- **Smooth the transition to the Encounter Data System** by slowing implementation.
- **Mitigate disruption for Employer Group Waiver Plans** by freezing implementation of the new payment system and revising the calculation methodology.
- **Improve the Stars Ratings System** by refining quality measures, with attention to measures related to care coordination and individuals with chronic conditions.
- **Improve county benchmark accuracy** by using Fee-For-Service Medicare data only from individuals with both Medicare Part A and B.
- **Provide greater flexibility** to allow better care for high cost, high need individuals with chronic conditions.
- **Empower beneficiary choice** by improving information that supports beneficiary decision making, including accurate provider directories and more comparison tools.
- **Offer greater public accountability and edification** through transparency and clarity on the purpose and impact of proposed policy changes, and access to data held by CMS for stakeholders and researchers.
- **Work with stakeholders to expand alternative payment models and promote best practices** in care management and the expansion of use of such practices.

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

**Reward Quality by Lifting the Benchmark Cap**

*Recommendation: BMA asks CMS to use its authority to lift the benchmark cap for high quality, 4-Star and higher Medicare Advantage plans. All Medicare Advantage beneficiaries deserve the full benefits of enrolling in a high quality plan and the current inequity hurts Medicare Advantage. CMS could also explore ways to suspend the cap in the interim to halt negative impacts in 2018.*

A key component of keeping Medicare Advantage strong is incentivizing improvements in quality using the Medicare Advantage Star Ratings System. The Star Ratings System successfully ties payment to quality, and incentivizes plans to improve quality in order to receive bonuses they must put towards reducing beneficiary cost sharing or increasing benefits. However, due to a policy known as the benchmark cap, in certain counties plans do not receive the bonus they earned and beneficiaries do not receive the full benefits of enrolling in a high quality plan. Across the country, over 40% of counties are capped and over 3 million Medicare Advantage beneficiaries live in these counties.<sup>1</sup> In 2016, over 2 million beneficiaries were enrolled in a 4-Star or higher plan, but are not receiving the full benefits they deserve because they were in a capped county.<sup>2</sup> For example, although BMA ally organization Indiana University Health (IU HealthPlans) received a 4-Star rating for 2016, 60% of the counties in which the plan operates have a benchmark cap, preventing 6,000 beneficiaries from receiving supplemental benefits.<sup>3</sup>

We were encouraged that CMS stated it shares concerns that the benchmark cap diminishes incentives for Medicare Advantage plans to continuously improve the quality of care provided to beneficiaries. We believe CMS has multiple pathways forward to lift or suspend the benchmark cap. This change would ensure Medicare Advantage effectively rewards quality and enables equal access to high quality care for all beneficiaries.

**Ensure Stability in Risk Adjustment**

*Recommendation: BMA supports the proposal to increase the coding intensity reduction by the statutory minimum. However, BMA is concerned with the disruption and uncertainty caused by annual changes to the risk adjustment system. Additionally, we encourage CMS to finalize a corrected Normalization Factor for all the risk adjustment models, including the ESRD model, to accurately reflect trend and avoid significant changes.*

Accurate risk adjustment is essential to ensuring all beneficiaries have access to Medicare Advantage and enables plans to have the resources required to meet the needs of beneficiaries. Effective risk adjustment supports early intervention, coordinated care, and better outcomes for beneficiaries, especially individuals with complex chronic conditions. We feel that the need for stability in risk adjustment was recognized in this year's decision to keep the coding adjustment increase constant.

We encourage CMS to create stability in the Normalization Factors and explore ways to reduce large impacts on payment in 2018 and in future years. CMS could potentially reduce disruptive impacts by finalizing the proposal to switch back to the linear factor, but also remove the outlier data from 2016. Additionally, we are especially concerned about the significant impact that could result from the proposed End Stage Renal Disease (ESRD) Normalization Factor. Advocates estimate that if the ESRD Normalization Factor of 1.080 is finalized, it could potentially reduce 2018 Medicare Advantage ESRD payments by up to 8% as compared to 2017. This is especially concerning since Medicare Advantage health plan data indicate that current payment for Medicare Advantage ESRD patients is already inadequate.<sup>4</sup> Further reductions to ESRD payment in Medicare Advantage could have a significant impact on beneficiary care for these vulnerable individuals.

**Smooth the Transition to the Encounter Data System**

*Recommendation: BMA supports the proposal to slow the move to encounter data as a diagnosis source by freezing implementation at the 2016 blend of 75% Risk Adjustment Processing System (RAPS) and 25% Encounter Data System. This slowdown in implementation will help provide the time needed to address inaccuracies and ease the implementation burden.*

BMA has articulated serious concerns to CMS about issues with the implementation of the transition to encounter data as a diagnosis source. These concerns have been echoed by a recent Government Accountability Office (GAO) report that concluded that limited progress has been made to validate the encounter data, which potentially results in inaccurate payments.<sup>5</sup> As expressed in the past, we have concerns that the Encounter Data System, as well as providers and plans, are not yet ready for the aggressive implementation timelines proposed in the past. Premature implementation of the Encounter Data System could result in inaccurate risk scores. We encourage CMS to continue to work with stakeholders, especially providers, to ensure the move to encounter data as a diagnosis source is accurate and effectively captures all diagnoses to accurately calculate risk scores. This should include developing and publicly releasing a strategy outlining how CMS plans to fix implementation issues. In the interim, we are supportive of an industry-wide adjuster that appropriately addresses any underpayments that resulted due to inaccuracies.

**Mitigate Disruption for Employer Group Waiver Plans**

*Recommendation: We recommend that CMS freeze Medicare Advantage Employer Group Waiver Plan (EGWP) payment at the 2017 payment methodology. We also ask CMS to revise the payment methodology so it accurately reflects the differences between EGWPs and non-employer plans. This should include calculating bid-to-benchmark ratios separately for Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) plans for the new EGWP payment methodology.*

EGWPs represent 20% of all Medicare Advantage beneficiaries and give retirees access to high quality, affordable coverage that allows employers to deliver on their commitment to employees. Employers, including governments, industries, and unions, have turned to Medicare Advantage to provide a seamless transition from employee to retiree health insurance coverage for large groups. We have serious concerns about CMS's proposed changes to the payment methodology for EGWPs and we recommend that CMS freeze payment at the 2017 ratios. Additionally, we ask that CMS revise the new methodology to capture the significant differences between EGWPs and non-employer Medicare Advantage plans. Retirees in EGWPs are enrolled in groups rather than as individuals. Additionally, coverage for retirees in EGWPs must include larger geographic areas than Medicare Advantage individual plans, and thus requires access to providers nationwide. Due to these group characteristics and broad networks, EGWPs are more likely to be PPOs than HMOs. Recent CMS data show that 74% of Medicare Advantage individual enrollment is in HMOs and 15% is in Local PPOs, whereas 34% of EGWP enrollment is in HMOs and 65% is in Local PPOs.<sup>6</sup> Therefore, we agree with the assessment of the Medicare Payment Advisory Commission (MedPAC) that it would be more accurate to calculate bid-to-benchmark ratios separately for HMO and PPO plans when calculating the ratios used for the new EGWP payment methodology.<sup>7</sup>

**Increase County Benchmark Accuracy**

*Recommendation: We ask CMS to increase the accuracy of the county benchmark calculation by including only data from FFS Medicare beneficiaries with both Medicare Part A and B.*

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MedPAC recently made a recommendation that Medicare Advantage benchmarks should be calculated using only FFS Medicare data from individuals with both Medicare Part A and Part B. Currently the data used to calculate benchmarks, and thus estimate average costs in a county, includes all FFS Medicare data, including data from individuals with only Part A (or only Part B). This results in less accurate Medicare Advantage benchmarks. We agree with this recommendation and urge CMS to improve the accuracy of the county benchmark calculation.

### Improve the Star Ratings System

***Recommendation:** We look forward to working with CMS to ensure future changes to the Star Ratings System successfully incentivize high quality care for all beneficiaries in all plans. We applaud the inclusion of telemedicine and attention to care coordination, transitions of care, and behavioral health. We have concerns about using audit and enforcement as measures for Star Ratings, and encourage CMS to focus on measures related to outcomes, care delivery, and beneficiary satisfaction.*

It is vital to BMA that the Star Ratings System effectively supports quality improvement for Medicare Advantage beneficiaries, including low income and disabled individuals. We recognize CMS's commitment to improving the current model for all beneficiaries and reducing administrative burden. We believe CMS should revise current policies that tie audit and enforcement actions to the Star Ratings, and specifically discontinue the application of any automatic downward adjustments to Medicare Advantage Star Ratings (individual measures and overall Star Ratings) based upon programmatic audit findings and compliance actions. We encourage CMS to include telehealth and remote access technology encounters as eligible encounters in various quality measures, including both Medicare covered telehealth services and telehealth provided using Medicare Advantage supplemental benefits. We support the work of CMS and the National Committee for Quality Assurance (NCQA) to explore more telehealth services, especially related to behavioral health services. We also look forward to working with CMS and NCQA to help research appropriate care coordination, transitions of care, and other measures related to individuals with multiple chronic conditions. We are currently engaged in research on the key components of effective care management, which include aligned incentives at the organization level, community engagement at the team level, and customized care at the patient level. We will share our findings with CMS.

### Provide Greater Flexibility

***Recommendation:** We encourage CMS to use its authority to increase flexibility for Medicare Advantage to better care for individuals with chronic conditions. This includes expanding the services that can be covered using rebate dollars as well as more inclusion of telehealth, and continued focus on Value-Based Insurance Design.*

CMS should give Medicare Advantage the tools it needs to innovate, and remove any barriers that impede access to high quality care. There should be more flexibility for the use of rebates so plans can direct those dollars to services that will have the largest impact on beneficiary care. This could include transportation or nutrition services not currently permitted. CMS should also explore ways to give greater flexibility for the use of new technologies, such as proven telehealth strategies, as well as flexibility to design benefits, cost sharing, and high value networks that result in higher quality care for beneficiaries.

### Empower Beneficiary Choice

***Recommendation:** We encourage CMS to promote ways to provide more information to beneficiaries to aide in decision-making. This includes improvements to the plan finder, increased accuracy of provider directories, and better comparison tools.*

We engage with thousands of beneficiaries, and the most powerful feedback we receive is about how complicated it is to navigate Medicare. Many of these individuals chose Medicare Advantage for not only

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the high quality care it provides, but also due to its simplicity compared to FFS Medicare. More can be done to help beneficiary decision making. For example, CMS recently released a report detailing inaccuracies in provider directories. We encourage CMS to work with all stakeholders to understand the causes and find a solution that will improve the accuracy of these directories. CMS should also explore other ways to improve the plan finder on Medicare.gov, including better comparison tools and ways to help beneficiaries weigh choices between Medicare Advantage and FFS Medicare.

#### **Offer Greater Public Accountability and Edification**

***Recommendation:** We encourage CMS to empower stakeholders by providing more guidance on key programs, as well as increasing transparency and access to analysis and data. Specifically, we call on CMS to work with stakeholders on the implementation of important programs like the Medicare Diabetes Prevention Program (MDPP). Additionally, we request that CMS remain committed to transparency by providing tools, such as impact analyses of proposals, to help stakeholders evaluate policy changes and give feedback.*

As advocates for Medicare Advantage, we appreciate the in-depth work CMS has done in preparing the 2018 Advance Notice and Draft Call Letter. BMA is committed to an evidence-based approach to supporting Medicare Advantage, and we find the analyses CMS provided in the proposed regulation useful. It is important to our alliance, and to all stakeholders, to have impact assessments – especially for complicated policies – in order to fully understand all proposed changes, assess the impact of those changes, and articulate the changes to our allies and other stakeholders. We know CMS values productive feedback, particularly on policy proposals that could improve the program and beneficiaries' access to benefits. Our work educating allies, beneficiaries, and researchers requires access to transparent and accurate data. More data and analysis will best enable well-informed responses to proposed policy changes and improve our ability to educate stakeholders on Medicare Advantage.

#### **Work with Stakeholders to Expand Alternative Payment Models and Promote Best Practices**

***Recommendation:** We look forward to working with CMS to identify and expand the innovative work being done in Medicare Advantage, particularly as it relates to effective care management strategies. We want to be a partner in the expansion of the use of best practices and also in the effort to promote the use of alternative payment models.*

BMA is committed to supporting the goals CMS outlined in the Call Letter, including improvement in quality of care for individuals and promotion of alternative payment models. We look forward to working with CMS to achieve these goals through research to identify best practices in care delivery and alternative payment models. In fact, recent research has found that the positive impact Medicare Advantage is having on care delivery is spilling over to FFS Medicare, resulting in reduced hospital costs to the system.<sup>8,9,10</sup> We are working with academic researchers to understand how Medicare Advantage is achieving these positive impacts, both through care management strategies and alternative payment models between plans and providers. We are currently working with research partners to develop best practices for care coordination by investigating “bright spots” in care coordination in Medicare Advantage. We will share our findings when they are completed.

#### **Conclusion**

Medicare Advantage is a public-private partnership that offers choice and value for Medicare beneficiaries. One in three beneficiaries or over 18.5 million people have chosen a Medicare Advantage plan. 92% of beneficiaries say they are satisfied or highly satisfied with their choice and studies show they stay in Medicare Advantage year after year. Beneficiaries in Medicare Advantage value the affordability, simplicity, care coordination, and enhanced benefits available under Medicare Advantage.

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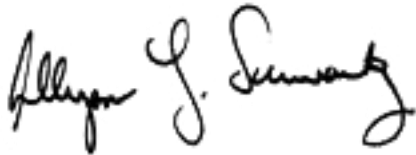
Providers, as well as beneficiaries, are more engaged than ever in Medicare Advantage, and are working with plans on system delivery models that are evolving to focus on teams, the identification of high risk, high need patients, and new community partnerships to improve care. The Medicare Advantage framework aligns incentives through the capitated financing system and value based arrangements to achieve improved outcomes and cost-effective high quality care.

Hundreds of policymakers, both Republicans and Democrats, have expressed their support for Medicare Advantage and reaffirmed their support for ensuring that Medicare Advantage is a strong option for Medicare beneficiaries going forward. Many recognize that Medicare Advantage is driving the change necessary to reduce costs and increase value in health care.

We conclude these comments by urging you to ensure that final changes in the 2018 Final Rate Notice and Call Letter reflect and support the goals and success of Medicare Advantage in providing coverage that enables early intervention and care coordination, reduces disease progression, and improves outcomes, particularly for those with multiple chronic conditions. Given the increasing number of baby boomers turning 65 and the impact of so many who face the challenges of living with serious chronic conditions, the value of Medicare Advantage is more important than ever.

We welcome the opportunity to work with CMS toward the shared goals of quality, choice, and value in the Medicare program.

Sincerely,



Allyson Y. Schwartz  
President & CEO  
Better Medicare Alliance

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<sup>1</sup> Better Medicare Alliance. The Impact of the Medicare Advantage Benchmark Cap on Beneficiaries (Issue Brief). October 21, 2016. [Web](#).

<sup>2</sup> Ibid.

<sup>3</sup> Indiana University HealthPlans 2016 data.

<sup>4</sup> Better Medicare Alliance. Caring for ESRD Beneficiaries in Medicare Advantage (Issue Paper). 2016. [Web](#).

<sup>5</sup> United States Government Accountability Office. "Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments." January 2017. [Web](#).

<sup>6</sup> CMS 2014 data.

<sup>7</sup> Medicare Payment Advisory Commission (MedPAC) Public Meeting. December 13, 2013.

<sup>8</sup> Chernew, M., Decicca, P., & Town, R. (2008). Managed Care and Medical Expenditures of Medicare Beneficiaries. *Journal of Health Economics*, 27(6), 1451-1461. [Web](#).

<sup>9</sup> Callison, K. (2015). Medicare Managed Care Spillovers and Treatment Intensity. *Health Economics*. 25(7). 785-928. [Web](#).

<sup>10</sup> Petterson, S., Bazemore, A., Jabbarpour., Wingrove, P. (2016). Understanding the Impact of Medicare Advantage on Hospitalization Rates: A 12-State Study. [Web](#).

# Better Medicare Alliance Allies

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Academy of Nutrition and Dietetics	Commerce and Industry Association of New Jersey
Aetna	Consortium for Older Adult Wellness
Alliance for Aging Research	Delaware State Chamber of Commerce
American Association of Nurse Anesthetists	Delta Dental of California, Pennsylvania, New York and Affiliates
American Association of Nurse Practitioners	Denver Metro Chamber of Commerce
American Benefits Council	Elder Services of the Merrimack Valley
American Medical Group Association	Florida Health Networks
American Nurses Association	Greater Philadelphia Business Coalition on Health
American Osteopathic Association	Greater Philadelphia Chamber of Commerce
American Speech-Language-Hearing Association	Healthcare Leadership Council
American Telemedicine Association	Health Care Transformation Task Force
Asian & Pacific Islander American Health Forum	Health Quality Partners
Association for Behavioral Health and Wellness	Humana
Atrius Health	Indiana University Health
Banner Health	International Council on Active Aging
Business Council of New York State	Iora Health
Central Ohio Primary Care Physicians Chamber of Commerce Southern New Jersey	Kentucky Teachers' Retirement System
ChenMed	LeadingAge
Coalition of Texans with Disabilities	Lehigh Valley Health Network
	LIBERTY Dental Plan Foundation

Meals on Wheels America	Area Agency on Aging of Palm
Mercy Health	Beach/Treasure Coast, Inc
National Association of Dental Plans	Pennsylvania Chamber of Business and
National Association of Health	Industry
Underwriters	Philadelphia Corporation for Aging
National Association of Manufacturers	Pittsburgh Business Group on Health
National Association of Nutrition and	Population Health Alliance
Aging Services Programs	Senior Resource Alliance
National Black Nurses Association	Silver Sneakers – a Tivity Health
National Caucus & Center on Black	company
Aging, Inc.	Society for Women’s Health
National Hispanic Council on Aging	Summa Health
National Hispanic Medical Association	Tivity Health
National Medical Association	Temple Health
National Minority Quality Forum	Texas Association of Business
National Retail Federation	The Garden State Chapter of the
NaviHealth	National Association of Hispanic
New Jersey Business and Industry	Nurses
Association	The Gerontological Society of America
New Jersey State Chamber of	The Latino Coalition
Commerce	UnitedHealth Group
New Jersey State Nurses Association	U.S. Chamber of Commerce
New Jersey Association of Nurse	University of Michigan Center for
Anesthetists	Value-Based Insurance Design
Northwell Health	Virtua
Nurse Practitioner’s Association of	VSP Vision Care
New York State	WomenHeart
	YMCA of the USA