March 3, 2017

The Honorable Tom Price
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Via Email to AdvanceNotice@2018cms.hhs.gov

Dear Secretary Price:

The U.S. Chamber of Commerce (the "Chamber") appreciates the opportunity to comment on the 2018 Medicare Advantage ("MA") payments in the Centers for Medicare & Medicaid Services ("CMS") Advance Notice of Methodological Changes for Calendar Year 2018 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and the 2018 Call Letter. As employers, our member companies remain committed to preserving the viability and continuity of trusted, meaningful coverage through MA plan offerings for their retirees. We appreciate your efforts to stabilize the Medicare Advantage Program and avoid undermining the health care coverage valued by millions of retirees and the employers that offer MA options.

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. Our members have long valued the ability to provide integrated retiree benefits through MA, including innovative care coordination and case management services, as well as the benefits and services offered under fee-for-service (FFS) Medicare. It is through MA that employers are best able to seamlessly transition retirees from active employee coverage to retiree coverage while maintaining stability in out-of-pocket health care costs.

There are multiple areas of concern in the 2018 Advance Notice and draft Call Letter including:

- The bid-to benchmark ratios in calculating the 2018 payments for Medicare Advantage Retiree Coverage through Employer Group Waiver Plans (EGWPs);
- The flawed normalization factors;
- The use of encounter data as a diagnosis source in 2018; and
- Several proposed changes to the Star Ratings methodology, particularly related to the impact of audit and enforcement action on Stars.

We are concerned that these proposed changes will have severe and negative impacts on the beneficiaries who depend on MA, by threatening benefits, increasing premium and cost-sharing amounts, and limiting provider access and plan options. The harm from these policy proposals

will undercut CMS' recent efforts to implement changes in FFS that mimic programs currently in place in the MA program that are working effectively, while improving care and lowering costs for beneficiaries.

Bid-to-Benchmark Ratios for Medicare Advantage Retiree Coverage through EGWPs

Employers offer health care coverage to approximately 3.7 million retirees through MA-EGWPs, 20% of all MA beneficiaries. MA-EGWPs allow employers to provide comprehensive coverage with out-of-pocket cost protections and prescription drug benefits through Part D, often at no additional cost to their retired seniors and the disabled. These EGWPs not only include more comprehensive benefits and superior care coordination and disease management programs; they also give beneficiaries greater guaranteed provider access and choice than traditional Medicare. Retirees highly value these MA-EGWPs and as of February 2017 20% of Medicare beneficiaries are enrolled in these EGWPs. MA-EGWP enrollment has grown rapidly since 2006, nearly tripling since that time, and increasing by nearly 2 million enrollees since 2010.

We continue to have concerns about last year's move towards abolishing the long-standing EGWP bidding process and instead tying payment levels to a blend of 2016 EGWP bids with the weighted average bid-to-benchmark rates associated with the individual non-group MA plans. Therefore, we urge CMS to reconsider last year's change in methodology. Instead of holding the methodology to the 2017 level or moving forward to fully implement the bid-to benchmark ratios for 2018, we urge CMS to revert back to the pre-2017 methodology of using EGWP experience as the determinant for costs and funding. We believe that the pre-2017 methodology best reflects the experience of the MA-EGWP population and their utilization and would better stabilize the market long-term. As we shared with Secretary Burwell last February when the 2017 Advance Call Letter was released:

> While in theory it may ***seem*** to make sense to have both MA-EGWP and MA individual plans linked to the same benchmark, a closer look at the significant differences between these coverage offerings demonstrates the harm in doing so. Simply put: EGWPs are very different plans which is why their bids have differed historically. Forcing these plans to accept the same payments as the average individual plan will lead to reduced benefits, increased cost sharing and/or limited access to providers. This in turn may impact the trend of lower hospital readmissions and fewer emergency room (ER) visits that has been well documented in the MA-EGWP market. A trend reversal like that will increase the overall costs to the health care system.
>
> While MA individual plans are largely HMOs, MA-EGWPs are typically Preferred Provider Organizations (PPOs) that cover larger geographies in order to accommodate employers with retirees living in various locations across the nation. Beyond offering retirees the ability to see providers outside of the network in the plan's service area for a slightly higher out of pocket cost in a typical PPO type offering, these plans also offer coverage to retirees in extended service areas, including numerous if not all states in the country. As a result MA-EGWPs tend to have higher associated premiums on average than individual MA plans. In addition, in order to offer national coverage, MA-EGWPs

> may operate in geographies where it is more difficult to establish efficient provider relationships to ensure appropriate risk coding. Consequently while EGWP members may appear to have lower average risk scores, this is more an artifact of the widespread geographic coverage than actual member risk.
>
> … this payment methodology will harm the viability of these plans and ultimately hurt retirees by increasing premiums, reducing benefits and restricting provider networks. If MA-EGWPs were no longer a cost effective option, employers likely would discontinue offering them to retirees leading to a return to unmanaged care, significant disruption for their retirees, and increased costs the Medicare program. We expect that this would reverse gains in health status and outcomes that have been the hallmark of managed care for employer groups before and after retirement.
>
> We urge CMS to help employers all over the country provide high quality, innovative, and coordinated care to their valued retirees by reversing the proposal to eliminate the [pre-2017] EGWP bidding process.

If CMS is unwilling to revert back to the pre-2017 EGWP bidding process, we urge CMS to at a minimum continue using the 2017 bid-to benchmark ratios and tying those benchmark ratios to direct pay PPO plans. Last year's change resulted in a significant reduction in MA funding for the MA employer groups. Retaining the 2017 ratio may help the employer group MA market for the time being.

Normalization Factors

The Chamber is very concerned about the normalization factors CMS proposes to apply for 2018. In particular, the growth in FFS risk scores between 2015 and 2016 is highly unusual and unexplained; it warrants further examination and adjustment. The fact that CMS's own per capita spending does not correlate to the growth in FFS risk scores between 2015 and 2016 exacerbates our concerns. Because 2016 appears to be an outlier data point, we recommend that 2016 be excluded from the calculation and that an amended normalization factor that more closely aligns with prior year trend be issued. This outlier data also impacts the calculation of the ESRD normalization factor. Given the frailty of this high-risk population, we recommend CMS similarly adjust the ESRD normalization factor to ensure stability of benefits and premiums.

Use of Encounter Data

In 2016, CMS continued the transition to encounter data-based risk scores calculating beneficiary risk scores based on blending data from both the Risk Adjustment Processing System (RAPS) (through which MA plans had historically submitted information about their members' diagnosis) and the Encounter Data System (EDS) (through which providers document both clinical conditions and services and items delivered to beneficiaries to treat these conditions). In 2017, there was a 75/25 blend, 25% encounter data and 75% RAPS data with the idea of eventually getting to higher levels of encounter data. For 2018, CMS proposed to maintain the same 75/25 blend. However, rampant operational and technical challenges have occurred with this change harming plans financially with many plans receiving lower risk scores which in turn

reduce their revenues. As we have asked for a roll back of methodological changes to EGWP initiated last year for 2017 plans, we urge CMS to also roll back the Encounter Data System (EDS) blend and rely solely on the data from the Risk Adjustment Processing System (RAPS) for determining risk scores. The Government Accountability Office's recent January report (titled Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments) and an additional GAO report in 2014 determined that CMS has yet to undertake activities that fully address the accuracy of encounter data and that necessary validation processes are not yet in place.

We recommend that CMS roll back these changes and revert back to a methodology that uses a 100% weight on RAPS data until a more complete analysis can be done to assure the impact to funding are appropriate and data being included is accurate. We recommend that CMS use only RAPS data in calendar year 2018 given the challenges in the present system and not move to any extended EDS/RAPS data blend until all challenges and processes are eliminated and the data is verified as being accurate for risk adjustment.

Star Rating

Employers are continuously developing innovative coverage offerings and exploring ways to help their employees manage and mitigate chronic conditions. Similarly, MA plans are advancing efforts to move beyond FFS towards a more integrated delivery system in the Medicare space. The Star Ratings program allocates financial rewards to MA plans with better health outcomes and performance. These financial rewards are then used by plans to provide additional benefits and to reduce cost-sharing amounts that would otherwise be borne by the beneficiaries.

While rewarding plans based on their outcomes and performance is appropriate, there are three proposed changes which have and will improperly undercut the goals of such financial incentive programs like Stars. There are several areas that we urge CMS to reconsider their approach and interpretation.

<u>Benchmark Caps and Bonus Payments</u>

First, we urge CMS to <u>exclude</u> the quality bonuses awarded to highly rated plans when testing the amount paid by CMS against the benchmark cap. Because CMS includes the bonus payments in testing against the cap, plans in many counties have much of the bonuses earned and due to them unfairly cut. This will undercut the very purpose of the quality bonus program and unfairly penalize plans that have invested and achieved higher Star ratings for their beneficiaries. Further, this interpretation and the payment determinations that will follow are going to create a chilling effect on the ability and incentive for insurers to invest in these valued improvement efforts. We believe that CMS has the statutory authority to choose to exclude these bonuses with the phrase included in the statue that directs that benchmark caps be "determined by taking into account the application of the bonus payment…" If the statutory intent had been to <u>*require*</u> CMS <u>*to include the bonuses*</u> when testing against the benchmark, it would have specifically stated

this.[1] Given that CMS has the authority to consider ("take into account") its inclusion and to assist CMS in this consideration, we urge CMS to assess the implication that including the bonus when measuring against the benchmark will have on plans that have invested in improving the quality of care provided to beneficiaries. In order to avoid discouraging innovation in certain parts of the country, CMS must allow issuers to recoup the investments made by providing higher quality of care as intended with these bonuses. Three million beneficiaries are now enrolled in plans in counties impacted by CMS's flawed interpretation of the benchmark cap. As a result, the plans of these three million beneficiaries are being denied access to additional dollars that generally would result in more benefits, lower cost sharing amounts, or lower premiums.

Star Ratings Mechanics: Prospective Thresholds

The Chamber urges CMS to establish and announce star rating cut points and thresholds prospectively for the following measurement year rather than after the fact. As Medicare Payment Advisory Commission (MedPAC) has said, "pre-set thresholds may be a better way of promoting improved quality." In addition to setting these cut-points prospectively, CMS should also limit the wide fluctuation of these points and increase consistency based on industry performance trends to facilitate long-term planning by providers and plans alike.

Separate Audit and Enforcement Actions from Star Ratings

The purposes and reasons for audit and enforcement actions are to oversee operational issues, while the Star ratings program is designed to focus on quality of care and beneficiary experience. CMS uses audits to review and evaluate plan operations and the quality of data reported on beneficiary issues such as coverage determinations, appeals, and grievances. CMS determinations, including the severity of the violations and the potential scope and degree of impacts on beneficiaries, can involve matters of interpretation. Based on its qualitative audit findings, CMS has the authority to take action against plans for noncompliance. In some cases, a single alleged incident of noncompliance can generate an audit finding and sanction. In contrast, the Star Ratings program is designed to produce a more quantitative measure of plan quality, based primarily on a robust set of clinical quality and performance measures combining beneficiary health outcomes, the delivery of preventive and chronic health services, patient experience, and access to care.

Not only do the audits and the Star Ratings measure different things and serve different purposes, but they also may have different timelines. A reliance on data that has no bearing on current performance is at odds with CMS's stated goal to provide information that is a true reflection of both plans' performance and the current experience of their enrollees. Given these concerns, we urge CMS to take steps to ensure that the Star Ratings program and the audit program accurately reflect the issues each are independently intended to measure, and that any link between the two should not result in plans being assessed duplicative penalties. We strongly believe that plans should not be penalized multiple times and in different ways for the same performance issue. We

[1] Please see the attached legal opinion which further details this discussion as to CMS's regulatory authority on this matter.

urge CMS to eliminate these duplicative penalties for plans beginning with the 2018 payment year.

Conclusion

The Chamber urges CMS to issue a final Notice that will further stabilize the MA program and preserve the ability for employers to continue offering these highly valued options. This is of vital importance to the millions of Americans with Medicare Advantage plans that they value and to the many employers that sponsor EGWP plans for their retirees.

Sincerely,

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