

Congress of the United States
Washington, DC 20515

March 4, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Slavitt,

We are writing regarding the Centers for Medicare and Medicaid Services' (CMS) Advanced Notice on February 19, related to proposed changes affecting the Medicare Advantage (MA) and Part D programs payments and policies for CY 2017. As always, we reiterate the importance of policies that both preserve beneficiary choice and ensure that seniors' access to coordinated care remains strong.

As you know, today, roughly one in three Medicare beneficiaries are enrolled in a MA plan. Millions of seniors have come to rely on MA plans, many of which offer supplemental benefits, reduced cost sharing, or innovative approaches to improve care.

We are pleased CMS addressed several previously identified key issues in the proposed notice. For example, CMS proposes to target resources to better serve "dual-eligible" beneficiaries who are eligible for Medicare and Medicaid.

We also appreciated the Agency's implicit recognition that MA plans could qualify as Alternative Payment Models (APMs). As envisioned by the Medicare Access and CHIP Reauthorization Act (MACRA), APMs allow for a large array of health care providers to participate in coordinated efforts to increase efficiency, lower costs, and bring higher quality care to our seniors and people with disabilities. We look forward to working closely with the Agency as implementation of MACRA continues.

Yet, despite these positive steps forward, we are concerned that other key policies proposed by CMS may not be appropriately targeted. Specifically, there are three key policy areas that raise some concern. We would appreciate if CMS could provide additional information to help us better understand CMS's proposed course of action.

- **Encounter Data:** In the CY 2016 proposed notice, CMS adopted 10 percent of encounter data as part of risk adjustment. At that time, Congress expressed concerns about the decision, noting that both the Medicare Payment Advisory Commission (MedPAC) and Government Accountability Office (GAO) analysis had determined CMS faced significant operational challenges before being ready to

use such data in an effective and balanced manner. Such a concern is still warranted. To better understand CMS action in this area, we have the following questions:

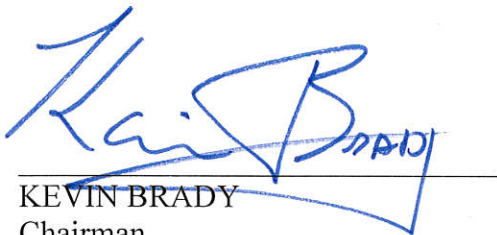
1. Has CMS modeled the impact of this proposed policy on plans? If CMS has done such analysis, please provide us with a summary. If not, what is the rationale for proposing such a change?
 2. What steps has the Agency taken to address the concerns outlined by MedPAC and GAO?
 3. What steps does CMS have planned to monitor the quality and utility of the data as is submitted by plans, and improve the quality and utility of such data going forward?
- **Employer Group Waiver Plans (EGWPs):** Many employers currently provide MA-based managed care retiree benefits to their retirees. However, proposed changes in the proposed notice could potentially disrupt these current arrangements without further review, particularly given the duration of existing plan contracts. Accordingly, we feel that CMS's proposed policy changes with respect to EGWPs should not be finalized in their current form. We are concerned that the proposed changes to the methodology may harm employers' ability to provide retiree benefits through a consolidated health plan encompassing both Medicare benefits and supplemental retiree offerings.
 1. Has CMS modeled the impact of this proposed policy on plans and beneficiaries? If CMS has done such analysis, please provide us with a summary.
 2. How does the policy proposed in this year's proposed notice differ from those policies that were proposed in the FY 2014 and FY 2015 President's budget?
 3. On what authority is CMS basing its proposal to make such payment changes administratively?
 4. One of the particular concerns with this proposal is that some EGWPs have multi-year contracts with employers, and/or have large regional coverage. Given the short time frame between when this policy is proposed, finalized, and when plans must modify practices, how does CMS plan to address these issues so changes are not disruptive to plan stability and beneficiary choice?
 - **Risk Adjustment Changes:** We appreciate CMS's continued work in addressing the impact of social determinants, including low-income status, on the Star Rating system, and view the proposals offered by CMS as a signal of the agency's commitment to this important effort. Given regional disparities, variation in plan enrollment of full and partial dual populations, and the adjustments that must be made to benefit structures and plan businesses, we think it is critical that CMS ensure plans are afforded a reasonable amount of time to adjust as these new policies are implemented.
 1. Given CMS's concern with respect to low-income beneficiaries who are dual

eligible beneficiaries, why did CMS not also propose policies to address disparities for low-income beneficiaries who may not be duals, but who may suffer from multiple chronic conditions?

2. CMS has modeled the impact of this proposed policy as having, on average, a small net negative impact on plans. Please provide us with a summary of CMS's methodology and analysis, as well as a summary of how this proposed policy impacts beneficiaries.

We stand ready to work with CMS on common sense policies that promote choice, encourage plan innovation to improve care, and ensure continued access to Medicare benefits through the MA program. We respectfully request the Agency respond to our questions as soon as possible and appreciate your consideration of our concerns

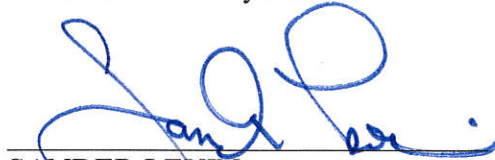
Sincerely,



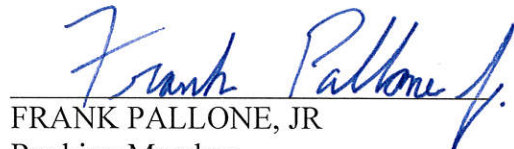
KEVIN BRADY
Chairman
Committee on Ways and Means



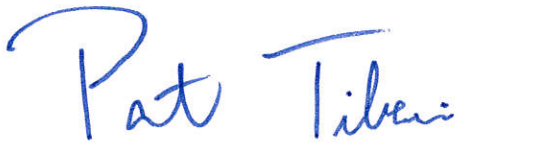
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