

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, DC 20515

March 3, 2017

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

Dear Secretary Price:

We are writing today regarding the Centers for Medicare and Medicaid Services' (CMS) Advanced Notice released on February 1, 2017, related to proposed changes affecting the Medicare Advantage (MA) and Part D programs payment and policies for CY 2018. As a defender of the MA program we look forward to working with you to preserve beneficiary choice and ensure that seniors' access to coordinated care remains strong. Today, nearly 18 million seniors, reflecting 31 percent of Medicare beneficiaries, across the country are enrolled in an MA plan which underscores the inherent value of these proposed policies and the impact they have on our seniors. Any proposal must both preserve beneficiary choice and ensure that seniors' access to coordinated care remains strong.

In addition to the growth in MA enrollment, access and plan satisfaction remains high amongst beneficiaries. According to the Medicare Payment Advisory Commission (MedPAC), the majority of seniors have access to a large number of plans and 90 percent of seniors report satisfaction with their plan.

We are pleased, that in this notice, CMS addressed a number of previously identified issues. For instance, CMS recognized our concerns, as well as those from the Government Accountability Office and proposed to pause a previously planned phase-in of encounter data. We encourage CMS to continue to work with plans to ensure data is accurate and complete before moving forward with the previously proposed phase-in.

The use of more recent data to calculate the Star Ratings and relief provided to sanctioned plans are positive aspects of the proposal. Finally, we are encouraged by CMS' continued commitment to the goal of finding a long-term solution to the unique challenges of serving our most vulnerable populations.

Despite these positive steps forward, we believe there are a number of other policy areas that deserve CMS' attention to ensure certain policies proposed by the Obama Administration do not jeopardize the quality and affordability of care our seniors rely on and enjoy. We would

appreciate if CMS could provide additional information to help us better understand CMS' proposed course of action on the following issues:

Employer Group Waiver Plans (EGWPs): For CY 2018, CMS is proposing to continue to waive the bidding requirements for all MA EGWPs, as well as other requirements finalized in the CY 2017 Final Notice. CMS also stated it is soliciting comment as to whether the proposed phase-in of the new payment methodology should continue or if the current CY 2017 methodology should be applied for CY 2018. We continue to be concerned that the new payment methodology will harm employers' ability to provide retiree benefits through a consolidated health plan encompassing both Medicare benefits and supplemental retiree offerings. We request that CMS reconsider the changes finalized by the previous administration as part of the CY 2017 Final Notice. Additionally, we request CMS to analyze, and make public, the impact of this proposed change prior to a full-phase in order to ensure the 3.2 million beneficiaries that were receiving coverage through an EGWP in 2016 are not losing access to their employer sponsored coverage, nor seeing their benefits reduced as a result of this policy.

Fee-for-Service (FFS) Normalization Factor: CMS has proposed to move back to the linear method to calculate the CY 2018 FFS normalization factor. In 2015, CMS changed to a quadratic method "to better capture the increased proportion of younger beneficiaries known as baby boomers." Understanding that this change back to the linear method would result in less of a reduction in payments to plans than the quadratic method, CMS should provide more information to plans regarding this methodology change. In the CY 2018 Final Notice, we request more details surrounding this change including historical projected normalization, actual FFS risk score trends (pre-2011), the challenges CMS faces in calculating the normalization factor, details on why the projected CY 2014 Part C normalization factor came in above actual FFS risk score values and what significant factors impacted the projected CY 2018 normalization factor to change as compared to the estimate under the quadratic method. Additionally, we are concerned with the proposed CY 2018 normalization factor for the ESRD Dialysis Model which is expected to result in an 8 percent reduction in payments to plans serving this high cost, complex need population.

Risk Adjustment: Over the years, changes to the risk adjustment model have made plans uneasy about what to expect year after year. For this reason, it is important that the model be as predictive, transparent and stable as possible. We urge CMS to work with the plans to create certainty and predictability in the modeling, as well as accurate accounting of certain chronic diseases, such as Chronic Kidney Disease. Under Section 17006 of the 21st Century Cures Act (P.L. 114-255), as of 2021, individuals suffering from end-stage renal disease (ESRD) will be allowed to enroll in a MA plan. As such, it is important that CMS' risk adjustment methodology properly adjusts for this population as required by law under Title XVII of the Social Security Act.

Benchmark Cap: Though we recognize the administration's limited Secretarial authority to remove quality incentive payments from the benchmark, we urge the Secretary to review all options at his disposal to ensure high quality plans are not missing out on

incentives to continue to improve care for our seniors. As CMS has recognized, the benchmark cap inherently undermines value-based care, negating the incentive for MA plans to reach higher levels of quality, by reducing or eliminating quality payments in many areas of the country. In certain counties, a 5-star plan could be paid the same as a 3-star plan. Our goal remains to encourage more plans to reach 4 or 5-star ratings.

Coding Intensity: Though CMS is required by law to set a minimum coding intensity adjustment, the administration does have some flexibility in setting this amount each year as of 2019. We urge CMS to consider the impact this automatic reduction will have on plans going forward.

Value Based Insurance Design (VBID) Model: As mentioned in the 2018 Advance Notice, beginning in CY 2018, CMS will expand testing of the existing VBID model to three more states. In an effort to fully evaluate whether or not savings are achieved without negatively impacting quality, we encourage the Secretary to consider a voluntary nationwide expansion that would allow any MA plan to participate during the testing phase, rather than picking and choosing certain states to participate.

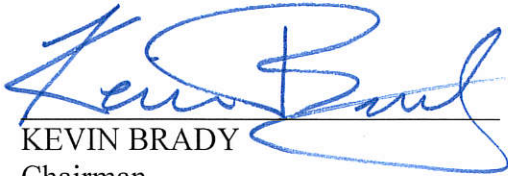
In addition to the issues raised in the CY 2018 Advanced Notice, we would encourage the agency consider additional policies to strengthen the MA program.

Benchmark Calculation: We request CMS consider using its authority to calculate the MA benchmark based on per county FFS spending for beneficiaries enrolled in both Parts A and B. As you know, MA beneficiaries are required to enroll in both Part A *and* Part B coverage, however, due to the current way the MA benchmark is being calculated, plans in certain areas are seeing lower benchmarks and ultimately lower payments. In the past, CMS has recognized the impact less Part B enrollees in an area has on the MA benchmark and has provided a similar adjustment for MA plans that service beneficiaries in Puerto Rico.

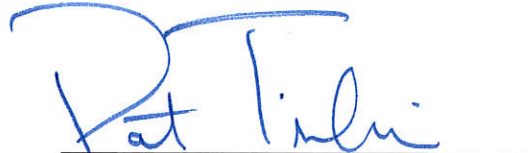
Alternative Payment Models (APMs): We urge CMS to review its authority to create a narrow adjustment for physicians participating in fully-capitated MA arrangements. A study by the Department of Health and Human Services found that MA organizations are, in varying degrees, already linking provider payments to APMs. As such, a number of providers have expressed interest in having their MA eligible arrangements count towards participation in APMs under Medicare Access and CHIP Reauthorization Act (MACRA).

Additionally, in the 2017 Final Physician Fee Schedule regulation published on November 4, 2016, the agency indicated possible guidance to MA plans on how to build in Merit-based Incentive Payment System (MIPS) adjustments to their payment rates to non-contracted providers would be addressed in future rulemaking. However, no such guidance was included in the CY 2018 Advance Notice. Due to the fact that MA plans are currently required to pay non-contracted providers the same rates as they receive under FFS, we request that the agency make clear their intentions to provide direction to MA plans on whether they will be able to access the MIPS data on providers.

During your time in Congress, you were a strong advocate for the MA program and we know you will carry those values with you to the Department of Health and Human Services. We remain committed to working with you 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 a response at your earliest convenience and appreciate your consideration of our concerns.



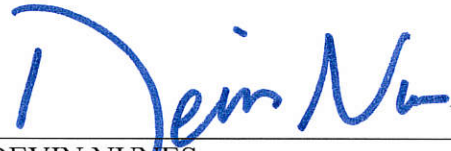
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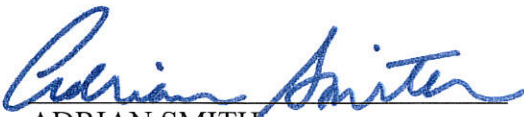
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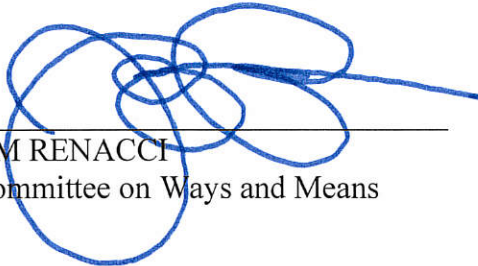
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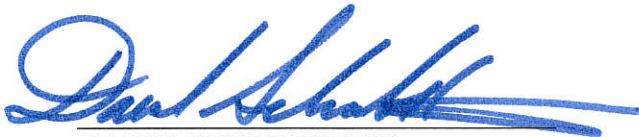
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