Congress of the United States

House of Representatives

Washington, D.C. 20515

March 13, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Administrator Tavenner:

Since the passage of the Affordable Care Act (ACA), the Medicare Advantage (MA) program has increased in strength. Enrollment is up by one-third, premiums are down by nearly nine percent, quality is improving, and 99 percent of beneficiaries have access to a plan. The ACA worked to rein in overpayments, which lowered Part B premiums for all Part B beneficiaries and extended Medicare trust fund solvency, and it added new benefits to Medicare. With approximately 70 percent of beneficiaries remaining in traditional Medicare, it is important to balance the needs of all beneficiaries and taxpayers as one evaluates current law and any changes.

The "Advance Notice of Methodological Changes for Calendar Year 2015 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter ("the 2015 Advance Notice and draft Call Letter") advances the important improvements made by the ACA and proposes further beneficiary protections. We support many of the provisions in the Advance Notice and Draft Call Letter, in particular those that provide greater value to beneficiaries and taxpayers. We are writing to highlight a few of the policies that we hope the Agency will retain in the final rate notice and call letter, while also asking for your consideration of several targeted concerns.

Proposed Payment Rate For 2015

We continue to believe that removing plan overpayments is the right policy course for Medicare and the nation. To reverse course would raise costs for taxpayers and all Part B beneficiaries, drain years from Trust Fund solvency, and expand beneficiary inequities that disadvantage the overwhelming majority of Medicare beneficiaries who remain in fee-for-service.

Lowering MA Payments Based on Fee-for-Service Rates

The MA payment growth rate is a result of a statutorily-required formula that bases MA payments on overall Medicare costs, which have grown more slowly in recent years. There has been a slowdown in Medicare spending growth in recent years, which is to be applauded; the

impact on rates should not be a surprise to plans. Insurers that choose to offer Medicare plans should not be insulated from market forces that are slowing the rate of growth of health care costs. Indeed, private plans often claim they are more effective than traditional Medicare at cost containment. We encourage CMS to continue to monitor the effect of these payment changes on beneficiary care and access.

Improving Accuracy of MA Risk Adjustment Payments

In compliance with statutory requirements, CMS proposed to apply a 5.16 percent downward adjustment to account for diagnostic coding differences between MA plans and fee-for-service providers. This adjustment reflects the fact that private plans code the health risk of their plan members more aggressively than fee-for-service providers, which makes MA beneficiaries look sicker than similarly situated beneficiaries in traditional Medicare. We recognize that there is strong policy justification to go even further, with the Government Accountability Office reporting to some of the signers of this letter last year that an improved methodology would justify even larger reductions to account for diagnostic coding differences between MA and FFS. We note that the President's budget also proposes a larger adjustment.

CMS exercised restraint in limiting the coding intensity adjustment to the lowest amount required by law. The agency also took other steps that were favorable to the plans by delaying a further phase-in of risk adjustment changes and proposing to use two years (2012 and 2013) of risk scores to calculate the annual trend of risk score growth, which accounts for the increasing population of baby boomers entering Medicare in a way that adjusts for risk score trends that is more favorable to the plans. This combination of policy decisions was in the plans' favor, and should be viewed as mitigating the rate changes required by the statute for 2015.

Excluding Health Risk Assessment Diagnoses from Payments

We support the proposal to exclude for payment purposes diagnoses identified during a home visit assessment that are not confirmed by a subsequent clinical encounter. However, we believe that home visits have the potential to improve care, when a beneficiary receives appropriate follow-up treatment, so we urge CMS to proceed with caution in the final operation of this proposal to ensure that it does not minimize the value of home visits. Home visits with proper clinical follow-up are an important tool to identify and serve the needs of MA enrollees; home visits should not be used merely to maximize reimbursement. Finally, we support CMS' proposal to use the Encounter Data System as an additional source of diagnoses data to calculate 2015 risk scores. We encourage CMS to continue to explore additional ways to improve the MA risk adjustment and ensure payment accuracy.

Protecting Beneficiaries

While some interested parties are solely focused on the rate changes proposed for 2015, we believe it is important to acknowledge and applaud the consumer protections proposed this year. It is important to note that the ACA improved Medicare's benefits, including those offered

by MA plans. Non-Medicare covered benefits, which are offered at the plan's discretion, have frequently changed from year-to-year, even prior to the ACA.

Protecting Beneficiaries from Cost Increases

We support CMS' proposal to again use its authority granted in the Affordable Care Act to protect beneficiaries from significant increases in costs or cuts in benefits. We are pleased to see that CMS is proposing to reduce the permissible amount of increase in total beneficiary cost to $32 per member per month and retain the current limits on beneficiary out-of-pocket spending. We recognize that plans need the flexibility to manage rate changes but believe they are able to, and should, do so without increasing burden on beneficiaries. For example, plans could reduce executive compensation or marketing expenses, among other options.

We also support the proposal to clarify guidance to indicate that beneficiaries' contributions toward these out-of-pocket spending limits are transferable when they move to any other plan, regardless of type, offered by the same MA organization.

Protecting Beneficiaries from Changes in Provider Networks

We are heartened to see the array of policy ideas the agency is considering to protect beneficiaries from unexpected changes in provider networks and encourage you to move forward on these program improvements for 2015 and subsequent years. We support the proposal to require Medicare Advantage Organizations (MAOs) to notify CMS of major network changes and provide a written plan of how the MAO will ensure enrollees can locate new providers, including how the plan will ensure continuity of care. As discussed in the Call Letter, we also strongly encourage CMS to use rulemaking to require plans to provide beneficiaries more advance notification when providers are being terminated from the plan network, to notify beneficiaries of other provider options, and to limit the ability of plans to terminate provider contracts without cause during a plan year. We point out that any notification to beneficiaries of other provider options should be sure to flag providers accepting new patients, otherwise such notice is meaningless. We also support the proposal to strengthen requirements in the Annual Notice of Change (ANOC) so that beneficiaries are explicitly told by their plan of their rights if a provider is terminated during the year. Finally, we encourage you to consider whether beneficiaries adversely affected by network changes mid-year ought to be permitted a special enrollment period (SEP) or, as part of continuity of care requirements, provided out-of-network care at in-network levels while finishing a course of treatment.

Innovations in Health Plan Design

We note that the Call Letter states CMS is looking to partner with private payers to test innovations in health plan design, including so-called "value-based" arrangements. While value based insurance design (VBID) might be a tool to help steer beneficiaries to clinically effective care, we are extremely worried that plans can use VBID to alter cost-sharing to further segment risk and cherry-pick among beneficiaries. MA plans have a history of using benefit design to attract healthier and less costly beneficiaries, and CMS oversight is often hampered by

inadequate resources. We urge CMS to use extreme caution in testing this model so that plans are not given another tool to favorably select among beneficiaries.

Star Ratings Program

We recognize that constructing the Star Ratings program is a delicate balancing act between appropriately rewarding consistently high-quality plans while providing financial incentives to plans that are steadily improving. We read with interest CMS' discussion of plans seeking special allowance in the Star Ratings program for serving a large number of low-income beneficiaries or other special needs plan (SNP) populations. In that discussion, CMS rejected the notion of a correlation between SNP enrollment and lower star ratings. We agree that these plans must be held to the same high standards as all plans. However, we have recently seen data from several plans indicating there may be an inverse relationship between the percent of plan membership that is low-income and its star ratings, with plans serving more low-income beneficiaries receiving fewer stars on the rating system. We ask you to take another look at the data to ascertain whether plans serving high numbers of low-income beneficiaries consistently fare less favorably in the star rating system, and if so, to explore the reasons why and whether there is an appropriate solution that would better reflect quality ratings and encourage continued improvement in those plans.

In closing, we believe that many of the policies proposed by CMS on January 10 will continue to improve the Medicare program. We encourage you to continue your work to strengthen Medicare for beneficiaries and taxpayers. We urge you to reject calls to weaken this regulation. Thank you for your hard work.

Sincerely,

Sander Levin
Ranking Member
Committee on Ways and Means

Henry A. Waxman
Ranking Member
Committee on Energy and Commerce

Jim McDermott
Ranking Member
Subcommittee on Health
Committee on Ways and Means

Frank Pallone, Jr.
Ranking Member
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