Congress of the United States
House of Representatives
Washington, DC 20515

March 20, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Acting Administrator Tavenner:

Over the past four years, Congress and the Centers for Medicare & Medicaid Services (CMS) have worked to strengthen the Medicare Advantage (MA) Program. These efforts have boosted beneficiary confidence in the program, and Medicare Advantage now has robust enrollment growth and better offerings than ever before.

Over the past three years, beneficiary premiums have remained stable. This year, for the first time, the Part D prescription drug benefit will have lower co-payments and a lower deductible than the previous year. All this is taking place in an environment where unjustified overpayments are being addressed. While Republicans predicted doom for the program if Congress reined in overpayments, Medicare Advantage remains strong.

The CMS 2014 Payment and Policy Updates for Medicare Health and Drug Plans, issued on February 15, 2013, continues that trend. We support many of the proposals in this recent CMS announcement and are writing to highlight particular policies that protect beneficiaries and that we hope the Agency will retain in the final policy announcement while also raising a few concerns we would like you to consider.

Basing Medicare Advantage Payments On Fee-For-Service Rates

Under current law, the Medicare Advantage growth percentage is tied to changes in the rate of per capita fee-for-service spending. Since fee-for-service spending is down, the MA growth rate is also down. This reduction is unsurprising and, in fact, is something to be applauded and for which we give credit to the Affordable Care Act. Medicare costs overall have grown more slowly than expected in recent years, and MA sponsors should not expect to retain what turned out to be excess payments from previous years. We recognize that CMS is statutorily mandated to tie MA payments to fee-for-service, and believe that doing so continues to be appropriate. Plans cannot pick and choose when they want to be based on fee-for-service based on when it is to their financial advantage. However, we recognize that payment changes can be disruptive and encourage CMS to evaluate and monitor the effect of these changes on beneficiary care.

Protecting Beneficiaries
We strongly support CMS' use of the authority granted in the Affordable Care Act to protect beneficiaries from significant increases in costs or cuts in benefits. We are pleased to see CMS reduce the amount of permissible premium increases and benefit cuts to $30 and retain the current limits on total beneficiary out of pocket spending. We support the proposal to allow beneficiaries to transfer their accrued contribution toward their annual maximum out-of-pocket cost sharing limit when they switch plans within a Medicare Advantage organization. However, we encourage CMS to further strengthen the protections for transferability of a beneficiary's contribution towards their maximum out of pocket liability so that it transfers from plan to plan, irrespective of the type or sponsor of the plan into which they are transferring.

We further suggest that CMS tread cautiously in expanding wellness programs. While certainly some such programs – if appropriately designed – may have positive effects, wellness programs can also have punitive effects on beneficiaries and that would be inappropriate.

Improving Accuracy of Risk Adjustment Payments
The Affordable Care Act required CMS to adjust for diagnostic coding differences between Medicare Advantage and fee-for-service by 4.71 percent; the American Taxpayer Relief Act of 2012 required CMS to further adjust this factor by an additional 0.2 percent. The Government Accountability Office, in a report requested by several of the signers to this letter, found that appropriate methodological changes would justify even higher adjustments to account for diagnostic coding differences between Medicare Advantage and fee–for-service Medicare. We are also glad that CMS is exploring additional ways to improve the risk adjustment. However, we have heard concerns that the removal of certain codes penalizes plans working to serve sickly populations. We ask that you carefully examine this proposal to ensure it does not disincentivize the type of care management of vulnerable populations we would like to see plans provide.

Star Rating System
We appreciate the Agency's improvements to the star rating system that have been implemented over time and urge CMS to continue to be aggressive in demanding quality from Medicare Advantage and Part D organizations. We support the intent of CMS' proposal to base the overall plan rating on raw scores rather than the average of star ratings for each individual measure. However, we have heard concerns that doing so results in "rate compression", pushing both high and low rated plans toward the middle. We ask that you carefully examine this proposal to be sure your methodology accomplishes your stated goal and does not inappropriately compress star rating scores. We support CMS' other proposed changes to the star rating system, including the updating of measures, changes to the low-performer icon, and changes that support the Million Hearts initiative.

Part D
We support a number of proposed policies related to pharmacy under Part D. Eliminating waste in the program protects both taxpayers and beneficiaries. The proposal to require pharmacies to obtain beneficiary consent prior to each new prescription and refill delivery to reduce waste holds promise, but we encourage CMS to monitor the consent requirement and suspend or adjust it, if necessary, to ensure beneficiaries have timely access to their medications. We further support the CMS proposal to protect beneficiaries from inappropriate use of prior authorization

forms, which could inappropriately restrict or steer a beneficiary to a pharmacy that does not meet their needs, but urge CMS to consider going further to standardize such forms.

Related to beneficiary needs, it is imperative that plans effectively monitor claims adjudication and process grievances and appeals; we urge CMS to require plan sponsors to have real-time access to these critical systems. We also support further investigation by CMS into "preferred" pharmacy networks, both in terms of out of pocket costs to beneficiaries, and to the program as a whole. The concept of a "preferred" pharmacy should not be used to inflate either taxpayer or beneficiary cost. Likewise, benefit structure should not be used to discriminate against or confuse beneficiaries, and we ask that CMS strengthen beneficiary protections related to cost sharing and tiering. No drug should be placed on a cost-sharing tier that exceeds the actual cost of the drug, for example, and allowing an excessive number of drug tiers as proposed will likely result in beneficiary confusion.

We strongly support CMS' proposal on measuring antipsychotic drug use among nursing home residents, but recommend CMS revise and expand the measure to include conventional antipsychotic drugs and also include all Part D covered nursing home residents, regardless of age.

Medicare Advantage Medical Loss Ratio

Finally, the Agency's implementation of the Affordable Care Act Medical Loss Ratio (MLR) requirement is critical. The MLR ensures that beneficiaries are getting value for their premium dollar, and maximizes the amount of premiums going to beneficiary care rather than overhead. We urge CMS to be aggressive in protecting taxpayers, beneficiaries, and the Medicare program as you work to finalize the proposed rules related to MLR.

We believe that many of the policies proposed by the Agency on February 15th are yet another step in the right direction. We encourage you to continue your work to strengthen Medicare Advantage in a way that ensures both beneficiaries and taxpayers benefit from these efforts. Thank you for your hard work in this area.

Sincerely,

The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce

The Honorable Jim McDermott
Ranking Member
Subcommittee on Health
Committee on Way and Means

The Honorable Frank Pallone, Jr.
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce