



800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

March 4, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (more than 100 of which sponsor health plans), and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) 2017 Advance Notice and Draft Call Letter.

The draft call letter presents several significant policy changes, as well as operational and technical modifications to the requirements for health plans to offer 2017 plans under the Medicare Advantage (MA) and Part D prescription drug benefit programs. As such, the letter addresses several areas of importance to hospitals and health systems, especially those that offer MA and Part D plans. Our comments pertain to these areas and address proposed changes to the risk-adjustment model, the star ratings program, risk scoring and other proposals. We also offer input into areas identified by CMS for future policymaking.

We are encouraged by CMS's proposed positive update to the MA and Part D payment rates and revisions to the risk-adjustment and star ratings programs. **On balance, the proposal for 2017 includes fair and sustainable rates to help ensure patient access to vital health care services, including important supplemental benefits.** However, we have concerns about several of the proposed policies, such as the rapid increase in the proportion of risk scores based on incomplete encounter data. Our specific comments follow.



PROPOSED POLICY CHANGES FOR THE MA AND PART D PROGRAMS

Risk Adjustment. CMS proposes several changes to the MA and Part D risk-adjustment model to better account for the cost of serving full dual-eligible beneficiaries and individuals with certain disease interactions. The AHA has long been concerned that CMS's Medicare payment programs do not sufficiently account for the influence of socioeconomic status (SES) on the cost of care. **We applaud the agency's proposal to begin to address this issue in the MA program by more heavily weighting fully dual-eligible segments in the risk-adjustment model. We also support CMS's proposal to account for interactions between psychiatric and substance abuse disorders within the disabled community.** On balance, we think that the proposed changes are feasible and will result in better alignment between the MA capitation rate and the actual cost of providing care to dual-eligible beneficiaries.

We do urge CMS, however, to monitor the results of this policy change. As CMS has acknowledged, the underlying analysis supporting the proposed policy change was based on fee-for-service expenditure data, because CMS does not have expenditure data for the MA population. CMS should conduct a robust and transparent analysis of the impact of this policy to ensure that: a) it achieves its intended effect, and b) that it does not inappropriately harm plans that do not have a high number of fully dual-eligible enrollees.

Star Ratings Program. CMS proposes to apply an SES adjustment to account for dual-eligible, low-income subsidy, and disability status to six measures within the MA star ratings program. Plans that serve a high percentage of such enrollees and delivery high-quality care may see an increase in their star rating. **The AHA applauds CMS's ongoing work exploring the impact of SES in the MA program, and believes the agency's proposal is a first step toward improving the fairness of the star ratings. However, we urge CMS to continue exploring SES adjustment approaches that account for a broader range of socioeconomic factors. Moreover, we strongly urge CMS to implement socioeconomic adjustment in all of its quality measurement and pay-for-performance programs, including those for hospitals.**

The AHA has long advocated that CMS incorporate socioeconomic adjustment into its programs when there is conceptual and empirical evidence supporting the need for adjustment. There is a strong and growing body of evidence that a number of patient characteristics impact health outcomes, health care utilization and cost of care. These include, but go beyond, the factors CMS proposes in the draft Call Letter. We point CMS to the National Academies of Medicine's (NAM) report, "Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors," which focuses on the social – not medical – factors that influence access to care, health care use, health outcomes and cost. NAM identified five domains of social risk: 1) socioeconomic position (SEP); 2) race, ethnicity and cultural context; 3) gender; 4) social relationships; and 5) residential and community context. **We ask CMS to continue to explore the impact of factors from each of these five domains, and whether they should be included in future SES adjustment approaches. Failing to fully account for these factors in the star ratings may inappropriately do a disservice to patients by diverting resources away from plans serving large proportions of disadvantaged patients and their network providers.**

We also urge CMS to monitor implementation of these changes to ensure that high-quality plans that do not enroll a high percentage of dual-eligible, low-income subsidy or disabled individuals are not inappropriately impacted. As part of the evaluation process, we also ask that CMS monitor how the star ratings change over time, and we suggest that CMS consider volatility in ratings year-over-year as one signal that the methodology may need revision.

Risk Scores. CMS proposes to update the blended risk scores by increasing the percentage based on encounter data from 10 percent to 50 percent. **The AHA has strong reservations about moving so quickly to rely on encounter data, which we believe has significant gaps.** We have heard of instances where physician billing systems limit coding to only four diagnoses; in other cases, providers without technology limitations choose to only code some diagnoses, not all. In both instances, provider undercoding could have a significantly inappropriate impact on plan risk scores. **We encourage CMS to transition more moderately to the use of encounter data by using this data for only 20 percent of the risk score in CY 2017.** Simultaneously, we ask that CMS conduct and publish data on the impact of transitioning to encounter data to address questions such as how such a transition would impact the average coding intensity over time.

Plans with Lower Maximum Out-of-Pocket (MOOP) Limits. CMS proposes to incentivize MA organizations to offer plans with lower MOOP limits by reducing the cost-sharing limits for skilled-nursing facility stays and certain other services. The agency also seeks input on other incentives it could offer to increase the appeal of offering such plans. While we agree with CMS's goal of increasing the number of plans available to beneficiaries with lower MOOP limits, we do not believe the proposed approach will have the intended impact because the broader limitations on benefit and cost-sharing design with the MA program challenge insurers' abilities to be creative and offer a wider range of plan options, including those that are lower cost.

Instead, the AHA encourages CMS to continue to explore flexibilities within the MA program that would allow plans to better meet the needs of different enrollee populations. Such flexibilities could include allowing MA organizations to tailor benefits within a plan based on beneficiary need or to allow coverage of social services and supports.

Opioid Addiction. CMS proposes to establish expectations for the role of Part D sponsors in addressing opioid addiction, including proposing that Part D plans implement edits to prevent opioid overutilization at the point of sale (POS) and reminding plans that they cannot establish barriers in beneficiary access to medication-assisted treatment. **The AHA supports CMS's increased focus on identifying, preventing and treating opioid abuse. However, we have concerns that POS edits may harm patients who legitimately need access to pain medications by delaying their care.** We instead propose that CMS direct plans to work with primary care and prescribing providers to alert them when one of their patients triggers a warning at the POS. Such information could include alerts to providers of the number of scripts the patient filled for opioids and the number of prescribers writing those scripts. Plans also could use this as an opportunity to educate providers on guidelines for safe opioid use and resources they can use to counsel their patients.

Drug Utilization. CMS proposes to implement a number of changes to the Part D program to address drug utilization, including allowing plans to limit a beneficiary's first fill for certain drugs to a one-month supply and encouraging plans to inform beneficiaries of additional drugs that become available on the formulary mid-year. **The AHA shares CMS's goal of reducing unnecessary drug utilization, but we encourage CMS to provide plans with greater flexibility to address this issue, such as by allowing plans to provide for split fills (e.g., 15-day fill) for certain drugs that have a high risk of negative side effects or might otherwise be discarded before the end of the month.** Allowing plans to offer split fill programs for those drugs could save the health care system significant expense.

With respect to mid-year formulary changes, we recommend that CMS encourage plans to alert prescribing providers – not beneficiaries – of these changes. Most beneficiaries do not have the medical expertise to evaluate whether or not a new therapy is a better option than their current plan of care. Providers, on the other hand, once aware of new therapy options may work with beneficiaries to determine the best option.

FUTURE POLICYMAKING

In addition to the above proposals, CMS seeks input on several areas of future policymaking. Below we provide input on several of these issues.

Alternative Payment Models. CMS seeks input on the challenges and concerns associated with the use of alternative payment models (APMs) in MA. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) creates incentives to encourage physician participation in APMs. Specifically, in 2019 through 2024, MACRA provides a bonus payment to qualifying physicians for whom a significant portion of their Medicare payments – and, in later years, payments from all payers – come from providing care through an APM. Qualifying physicians also will be exempted from the reporting requirements in the Merit-based Incentive Payment System. MACRA establishes some general requirements for APMs; however, CMS will need to identify through rulemaking the specific models that will qualify as APMs.

In our response to the agency's Request for Information on Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models, we urged CMS to provide the greatest opportunity possible for physicians who choose to become qualifying APM participants. Specifically, we suggested CMS:

- Consider both the patient population served by a physician and the payments made through an APM when determining whether a physician meets APM thresholds;
- Cast a wide net when capturing physician participation in APMs; and
- Define “financial risk” in a manner that acknowledges the significant investment providers make to participate in APMs.

Given the increasing prevalence of MA, the AHA urges CMS to explore ways to capture risk-sharing arrangements for care provided to beneficiaries enrolled in MA plans in the APM framework consistent with our recommendations above.

Interoperability between MA Plans and Providers. CMS states in the Draft Call Letter that it is exploring how best to encourage the adoption of technology that supports interoperability between MA plans and their providers and seeks comment from stakeholders regarding their experience with these activities. Hospitals, health systems, plans and other stakeholders have collectively invested hundreds of billions of dollars implementing electronic health records and other health information technology (IT) tools that do not easily share data to support care, engage patients or provide data and analytics to support new models of care. Failing to resolve the interoperability challenges contributes to excess spending on inefficient work-arounds, inadequate data to support new models of care and continued accusations of “information blocking.” The AHA continues to advocate for more consistent use of standards, better testing of health IT and more transparency about vendor products to ensure that we have efficient and effective infrastructure in place to support sharing of information for care, engage patients and implement new models.

One area of particular challenge to sharing clinical information between providers and health plans is in transactions used for billing and paying for health care services (HIPAA transactions). We strongly encourage that any work to improve interoperability between plans and providers take into account principles of administrative simplification and, specifically, incorporate the attachment standard, which was designed to facilitate the sharing of supplemental medical documentation to support information found on the claim but that cannot be accommodated within the format of the claim. We encourage CMS to see our more detailed comments on the attachment standard as part of [our testimony](#) before the National Committee on Vital and Health Statistics (NCVHS) last month. In addition to our support of the attachment standard we recommended that additional efforts to increase the utilization of the pre-authorization standard would reduce the financial fear that patients may have about the coverage of an upcoming visit.

As evidenced by our testimony to the NCVHS, the AHA works with a range of public and private sector partners to identify the best approach to determine national priorities for advancing interoperability and mechanisms for accountability. We look forward to working with CMS to better understand the specific challenges providers and MA plans face when attempting to share information and encourage CMS to provide ample opportunity for stakeholder engagement in the development of any future policy.

Provider Directories. Today, the provider directory requirements for the MA program are not as rigorous of those required for Qualified Health Plans in the federal marketplace and Medicaid managed care organizations. **The AHA supports CMS’s goals of strengthening the provider directory regulations for MA plans, as well as aligning them with other government programs.**

The AHA has submitted comments to CMS previously supporting requirements that plans maintain and update provider directories and make the directories available in electronic or paper

Andrew M. Slavitt

March 4, 2016

Page 6 of 6

form. We also submitted comments to the National Association of Insurance Commissioners (NAIC) in the development of its model act for network adequacy that supported provisions that would improve the availability and accuracy of provider directories. The maintenance and updating of provider directories is an important component of ensuring an adequate network. We recommended that health plans update directories at least monthly and conduct periodic audits to ensure the accuracy of their directories.

The AHA also urges CMS to explore ways to standardize provider directory information. CMS should consider adopting the provider directory standard listed in the Department of Health and Human Services (HHS) Office of the National Coordinator for Health IT's draft of the "2015 Interoperability Standards Advisory."

OTHER COMMENTS – DRUG PRICING

CMS notes several times in the 2017 Advance Notice and Draft Call Letter the impact that unanticipated and excessive increases in drug prices is having on the Part D prescription drug program. The AHA strongly urges CMS to evaluate its options to help address the rising cost of drugs, which is completely out of line with inflation and the annual change in cost of other health care products and services. These drug costs are crippling insurers' and providers' ability to best serve patients and are risking patients' health by making critical drugs financially out of reach. While significant attention has been paid to branded and specialty drugs, manufacturers have dramatically increased the prices of many of their generic drug products as well. These costs are ultimately borne by patients and taxpayers in the form of higher premiums and co-pays and a higher portion of their tax dollars dedicated to drugs. **We encourage CMS to work with the AHA, the Campaign for Sustainable Rx Pricing, your colleagues at the Food and Drug Administration and National Institutes of Health, and other stakeholders to identify options for containing runaway drug prices.** The AHA is in the process of evaluating workable policy options to address this crisis and looks forward to sharing them with CMS when they are available.

Thank you for your consideration of our comments. We look forward to working with you and your staff on this, and subsequent, MA rule making. If you have any questions, please contact Molly Smith, senior associate director of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President