American Hospital Association

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March 6, 2015

Andy 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 to Calendar year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter

Dear Mr. Slavitt:

On behalf of the American Hospital Association's (AHA**)** member-sponsored Medicare Advantage Organizations (MAO), I write to express our concerns regarding the Centers for Medicare & Medicaid Services' (CMS) Medicare Advantage (MA) payment policies announced in the 2016 Advanced Notice. While several of the proposed policy changes would improve the MA and Medicare Part D (MAPD) programs for beneficiaries and provider-based MAOs, the continuation of payment cuts is very concerning. Cutting MA and Part D plan payments by 0.95 percent, on average, for 2016 continues a trend that will negatively impact plans, providers and beneficiaries.

America's hospitals have been moving aggressively toward payment systems that reward value over volume, incentivize the integration of payment and care delivery, and place an emphasis on quality and access. To this end, many hospitals either now have an MAO, are planning to add an MAO or are looking to share risk with an MAO because MA serves a critically important population, values care integration and rewards quality and access. These hospital-based plans bolster the affordable plan choices available to Medicare beneficiaries across the country, enable beneficiaries to access high-quality providers who share common records and can coordinate their care, and offer value-added benefits and services beyond what basic Medicare covers.

A sustainable MA program is in the best interest of the 30 percent of beneficiaries who choose such plans. Medicare beneficiaries should have a selection of high-quality plans that include affordable premiums and cost sharing, and access to the value-added benefits on which MA beneficiaries have come to rely.

2016 MEDICARE ADVANTAGE AND PART D PAYMENT POLICIES

The AHA is greatly concerned that, in the 2016 Advance Notice, CMS plans to continue the pattern of cuts to the MA and MAPD programs that will result in negative consequences for Medicare beneficiaries, including increased premiums and cost sharing, narrowing of provider networks, and reductions to non-Medicare benefits. Cuts in MA and MAPD payments have a significant downstream impact on beneficiaries and providers.

Our members with longstanding MA and MAPD plans have been models for other hospitals that are considering similar strategies. **However, the continuing cuts, including those planned for 2016, make the MA program less practicable and may curtail the expansion of provider-based MA plans or even reduce participation, resulting in fewer provider plan options for beneficiaries.**

In addition to the proposed average rate cut, CMS intends two significant changes to the risk-adjustment model. First, CMS seeks comment on a proposed new coding pattern adjustment that would begin in 2017. CMS proposes to cap total risk-adjustment payments at pre-2000 levels. By doing so, CMS would establish a fixed pool of risk-adjustment dollars whereby improvements in risk scores might become a zero-sum game in which a plan can only improve its risk-adjusted payments if another plan's is reduced. There is little detail in this proposed methodology; however, **the AHA is very concerned that this would result in reduced payments to MA plans on the back of other cuts to the program, as well as limit the benefit of risk-adjustment, which is needed for the sustainability of plans that enroll higher-acuity populations**. The AHA does not recommend that CMS proceed with this new methodology for 2017 without further development and input from stakeholders. Second, CMS proposes to begin including encounter data in the risk score calculation at a blend of 10 percent to 90 percent for diagnosis data from the Risk Adjustment Processing System (RAPS). **The AHA is supportive of this potential improvement, but cautions CMS against expanding the rate blend for the encounter data until the impact on plan payments is fully understood and documented, and plans have an opportunity to review and comment.**

OTHER MA POLICIES OUTLINED IN THE DRAFT 2016 CALL LETTER

Our comments on the daft call letter fall into three main categories: home risk assessments, quality stars measurement and other issues.

Home Risk Assessment. The AHA is pleased to note that CMS has taken a fresh approach to the application of in-home health risk assessments (HRA) to both care delivery practice and risk-adjustment coding. As CMS acknowledges, in-home HRAs have become effective tools for engaging enrollees, assessing their medical and non-medical needs, establishing care delivery plans, and facilitating visits with medical and non-medical professionals. HRAs are also important for gathering diagnosis information that is required to support risk score development. Given the wide range of use of HRAs among MA plans, **the AHA supports CMS's proposal to define best practices and expectations, as opposed to restrictive regulations, so that MA enrollees benefit as much as possible from these in-home visits**.

Quality Stars Program. **The AHA commends CMS for taking an important step toward recognizing the impact of socioeconomic factors on quality performance by reducing the weight of six measures in determining star ratings.** A growing body of evidence demonstrates that performance on many quality measures is influenced not only by the actions of health plans and providers, but also by a range of socioeconomic factors beyond their control, such as poverty and access to resources in the community that support health. Failing to account for these factors in comparing quality performance can lead to some plans and providers scoring more poorly on measures than others simply because they care for larger proportions of disadvantaged patients.

CMS has been investigating the extent to which dual eligibility for Medicare and Medicaid – a proxy for low socioeconomic status – is associated with poorer performance on MA star rating measures. CMS found that six measures had "practical and statistically significant evidence" of different outcomes for dual-eligible beneficiaries. As a result, CMS proposes to reduce the weight of these measures in calculating overall star ratings, acknowledging that socioeconomic status may result in lower relative quality ratings, thus penalizing these plans for enrolling disproportionately more dual-eligible members. The agency views reducing measure weights as an "interim step" while it conducts additional research on the necessity of such adjustments and on longer-term methodological approaches. **The AHA strongly encourages CMS to continue assessing the impact of socioeconomic status on MA star ratings, and to update its star ratings approach accordingly. We also strongly urge CMS to consider the applicability of its interim approach for MA star ratings to the agency's other quality programs where some providers may be disadvantaged by caring for larger proportions of poor patients.**

Other Issues. **The AHA applauds CMS's intention to monitor closely MA plans' networks for adherence to network adequacy standards.** According to the draft call letter, MAOs are expected to establish and maintain a proactive, structured process that enables them to assess, on a timely basis, the true availability of contracted providers, which includes, as needed, an analysis to verify continued compliance with applicable network requirements. In some instances, provider directories have been found to contain physicians who are not accepting new patients or who are no longer practicing. By securing an outside contractor, establishing audit protocols and enforcing regulations, CMS is better positioned to ensure that beneficiaries have easy access to up-to-date provider information.

The AHA appreciates that CMS is proposing to make exceptions and appeals more accessible for beneficiaries. This is a source of great confusion and frustration for patients and providers. Enforcing requirements for plans to state clearly the specific reasons for denials, as well as including a reference to the specific Medicare rule or plan policy will not only cut down on enrollee confusion but also make the appeals process easier to pursue. CMS reminds MAOs that they often must request supporting information from providers when making decisions on exceptions and appeals.

In the Advance Notice, CMS proposes to request information from MAOs on value-based contracting in 2016. Many MAOs and provider organizations are engaging in new and creative arrangements that share financial risk and emphasize expanded care management and

coordination. Value-based arrangements, such as these, aim to reduce costs while improving health outcomes and enrollee satisfaction. The AHA and its members are supportive of these types of arrangements and have been moving aggressively to value-based models, and we support the agency's collection of information to study their impact. We also are pleased to learn that CMS will engage with other stakeholders, such as hospitals and other providers, when determining best practices and exemplary innovations. In the Call Letter, CMS signals that these requests for information may be formalized in future rulemaking. We look forward to providing information at that time.

Finally, the AHA is encouraged by the CMS proposal to decouple emergent and urgent care from applying to an enrollee's deductible. Separating these services from the deductible means that the enrollee can seek services with the confidence that he or she has first-dollar coverage, meaning the enrollee will not be financially liable for more than his or her copay or coinsurance amount. However, **the AHA encourages CMS to allow the copay or coinsurance amount paid out of pocket to count toward fulfilment of any plan deductible that exists**.

We appreciate your consideration of these issues and look forward to continuing to work with CMS. If you have any questions, please feel free to contact me or Jeff Goldman, vice president coverage policy, at (202) 626-4639 or jgoldman@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis & Development