



**National
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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

March 5, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
200 Independence Ave SW
Washington, DC 20201

Submitted electronically via: <https://www.regulations.gov/>

RE: Docket ID CMS-2017-0163, Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rate, Part C and Part D Payment Policies and 2019 draft Call Letter

Dear Administrator Verma:

The National Business Group on Health (NBGH or the “Business Group”) appreciates the opportunity to comment on the 2019 Advance Notice and Call Letter. We applaud CMS for continuing to enact and refine policies to promote an efficient Medicare Advantage program, which offers Medicare beneficiaries comprehensive private health care plans with access to innovative programs, similar to those enjoyed by millions of Americans through private employers. By offering an alternative to the traditional fee-for-service system and providing disease and care management services that reduce hospitalizations and improve care, Medicare Advantage has reduced health care costs and promoted high-value care in a vulnerable and typically high-cost population. These plans also offer additional benefits not offered in traditional fee-for-service Medicare, such as vision, hearing, dental, and/or health and wellness programs, and most also include prescription drug coverage.

The Business Group represents 420 primarily large employers, including 75 of the Fortune 100, who voluntarily provide group health and other employee benefits to over 55 million American employees, retirees, and their families.

Within the advance notice and call letter, we have specific concerns about the following:

- **Employer Group Waiver Plans (EGWPs):** The EGWP program is one that many employers who offer and support retiree health coverage rely upon to seamlessly transition their Medicare-eligible former employees and their spouses into the Medicare program with benefits similar to the company-provided benefits to which they were accustomed. The Business Group opposes a full transition in 2019 to using only individual bid-to-benchmark (B2B) ratios to set EGWP payments, as initially discussed in the 2017 Advance Notice and Rate Announcement. We recommend retaining the 50/50 blend of individual and EGWP bids for 2019 and urge CMS to study alternative methods. We expand on these comments in the attached addendum.

- Risk Adjustment and Encounter Data:** We have concerns about shifting 2019 risk adjustment payments to a weight of 75% for risk adjustment payments calculated using the 2017 CMS-HCC model and weight of 25% for payments calculated using the new CMS-HCC model applied to encounter and FFS data. Although the proposed changes are primarily intended to address underpayment by the current model for certain conditions – specifically, chronic kidney disease, mental health, and substance abuse, we have concerns that about the accuracy of the encounter data used under the new model. In fact, two recent studies from Milliman and Avalere found that risk scores calculated based on encounter data were 4 percent to 16 percent lower on average in comparison to the current data system, resulting in substantially reduced reimbursements for beneficiaries in Medicare Advantage plans. We encourage CMS to consider ways to simplify improve the accuracy of the data collected, as well as methods for data validation before increasing the reliance on encounter data.

Additionally, we support the following:

- Part D Opioid Overutilization Policy:** We support CMS’ efforts to place increased scrutiny on opioid medications, which are associated with serious risks of addiction, overdose, and death. In response to the growing epidemic, employers have also been actively engaged in better understanding how to identify high-risk populations, and target and tailor treatment options for employees. As part of these efforts, employers have implemented similar policies to those outlined in CMS’ proposal, including drug utilization review (DUR) programs, implementing the Guidelines for Prescribing Opioids for Chronic Pain, as outlined by the Centers for Disease Control (CDC), limiting supply, and lock-in programs, to name a few. Recognizing the direct and indirect economic and societal costs of this epidemic, we applaud CMS’ efforts to provide common sense and rational approaches to better tracking of these medications.
- Quality Payment Program:** We support allowing additional ways for eligible clinicians to become QPs that considers their participation not only in Advance APMs, but also in innovative alternative payment arrangement through other payers such as Medicaid, Medicare Advantage and commercial payers (Other Payer Advanced APMs).
- New Measures for 2019 Star Ratings:** We support CMS’ inclusion of the Pharmacy Quality Alliance (PQA) measure to initiate statin therapy in persons with diabetes, as well as the National Committee for Quality Assurance (NCQA) measure to initiate statin therapy in patients with cardiovascular disease. We further support CMS’ proposed enhancements to medication adherence for hypertension and diabetes medications, as well as cholesterol medications.
- Potential New Measures for 2020 and Beyond:** We support the new efforts being proposed by CMS, especially:

 - The focus on improving transition of care with four new indicators relative to admission, discharge, engagement after discharge, and medication reconciliation.
 - A proposal to assess follow up care provided after emergency department visits for patients with multiple chronic conditions.
 - The new proposed care coordination efforts, consistent with those being increasingly focused on by large employers.

- The adoption of PQA's opioid measures, aimed at collecting data on the use of opioids at high doses and the use of opioids from multiple providers.
- **Medicare Advantage Value-Based Insurance Design Model test:** We support the expansion of the VBID program to California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia and West Virginia. The VBID program provides an opportunity to offer supplemental benefits or reduced cost sharing to enrollees with approved chronic conditions, focused on the services that are of highest clinical value to them. Expansion of this program serves to expand smart payment policies across a wider geography of Medicare beneficiaries.

In closing, we applaud CMS for making the important and detailed refinements within the 2019 call letter. We appreciate CMS' recognition that Medicare Advantage plans need the ability to be flexible, to tailor care to individual health needs and urge CMS to continue to maintain this flexibility in the future.

Again, thank you for the opportunity to comment. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail.

Sincerely,

A handwritten signature in black ink that reads "Brian Marcotte". The signature is written in a cursive, flowing style.

Brian Marcotte
President and CEO

Addendum

Employer Group Waiver Plans (EGWPs)

Employers that provide retiree health coverage are increasingly seeking innovative ways to manage costs while offering high-quality retiree benefits. Medicare Advantage Employer Group Waiver Plans (EGWPs) have proven to be an attractive option, as a customized plan option, developed exclusively for employer and union groups. CMS has historically waived or modified certain Medicare Advantage requirements for EGWPs. That is because CMS has determined that those requirements hinder the design of, the offering of, or the enrollment in employer/union-sponsored plans.

EGWPs provide employers the opportunity to fulfill their promise to maintain consistent coverage for their retirees. EGWP Preferred Provider Organizations (PPOs) allow employers to maintain this commitment, regardless of where retirees choose to live. While the individual Medicare Advantage market is comprised mostly of local health maintenance organization (HMO) plans, over 70 percent of EGWPs are PPO options, tailored to serve retirees living in widespread areas.¹

We recognize that the Medicare Payment Advisory Commission (MedPAC) recommended in 2014 that CMS base payments to EGWPs on comparable non-employer plans, based on its finding that EGWPs bid, on average, about 9 percent higher than non-EGWPs. However, given that most EGWPs are local PPOs as described above, they generally provide greater access to out-of-network providers and therefore generally incur higher costs. By comparison, only 16 percent of non-EGWP Medicare Advantage plans are local PPOs. MedPAC's analysis and recommendation to change the payment methodology for EGWPs does not account for the differences between Medicare Advantage PPOs and HMOs

EGWPs are highly valued by 3.7 million Medicare beneficiaries. Using bids that mostly reflect HMO structures to set payments for plans that mostly offer PPO structures could cause unintentional coverage disruption for retirees. CMS should take steps to reverse these flawed payment reductions. At a minimum, we urge CMS to maintain the payment methodology that was applied in calculating the 2017 and 2018 EGWP payment rates, for 2019. These were calculated using a blend of all individual market plan bids and all EGWP bids from 2016, each weighted by 50 percent to determine the B2B ratios by quartile. We further urge the agency to study alternative ways to more properly account for the distribution of enrollees in PPO vs HMO plans.

¹ Avalere Health analysis using enrollment data released by the Centers for Medicare & Medicaid Services. July 2017.