MEDPAC Medicare Payment Advisory Commission

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Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-4069-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled *Medicare Program; Establishment of the Medicare Advantage Program*. We appreciate that your staff has an enormous task in implementing the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), particularly given the agency's competing demands. CMS must strike a balance among policy goals that sometimes compete with one other. We appreciate the complexity of CMS's task in striking this balance, and MedPAC intends for its comments to help CMS in that mission.

As you requested, our comments are organized and identified by the corresponding sections in the proposed rule.

Subpart B–Eligibility, Election, and Enrollment

Specialized MA plans

The MMA introduced a new type of coordinated care plan – specialized MA plans – which would exclusively serve beneficiaries with special needs. Beneficiaries with special needs are defined as institutionalized beneficiaries, beneficiaries eligible for Medicaid (dual eligibles), or beneficiaries that the Secretary determines could benefit from enrollment in a plan for individuals with severe or disabling chronic conditions. The ability for plans to limit enrollment to certain subgroups of Medicare beneficiaries may produce more efficient plans that can deliver higher quality care to some types of beneficiaries. The potential benefits of limiting enrollment must be balanced against the potential problems of segmenting beneficiaries by health status and plan opportunities for risk selection.

In the proposed rule, CMS has requested input on how to identify subgroups of beneficiaries that would be appropriate under the chronic condition definition. Chronic condition plans should be based on conditions for which alternate care delivery models, such as disease management, and evidence-based medicine practices exist. In setting priorities, the conditions selected should also be expensive and prevalent for there to be savings and risk-management potential, although plans are responsible for the entirety of care for their members. Additionally, because payments for beneficiaries with costly conditions would be high, the potential gains from skimping on quality also would be high. Therefore, the conditions selected should be associated with recognized quality measures because CMS should carefully monitor quality delivered by specialized plans to protect vulnerable beneficiaries and the Medicare program.

One chronic condition that could meet these criteria is ESRD. While we support allowing ESRD beneficiaries to enroll in all MA plans, MedPAC believes that specialized plans for ESRD beneficiaries would also be appropriate given the successful demonstration program for beneficiaries with ESRD in the past. Other possible chronic condition subgroups could include diabetes and congestive heart failure. CMS would need to watch for problems with financial solvency of specialized plans, as the threat of plan failure would be higher if there were a smaller population over which to spread the risk. Also, CMS might need to refine the risk adjustment model for plans that specialize in one population, as the current system is designed for plans that serve a cross-section of beneficiaries.

Subpart C–Benefits and Beneficiary Protections

Network adequacy flexibility

CMS is proposing that regional MA plans need not always have a comprehensive network in place in all areas, but instead be required to offer members reasonable access to in-network cost sharing.

In principle, this may be a wise approach, but CMS would need to carefully to carefully monitor situations to avoid potential problems. One problem situation could arise if plans did not have primary care providers in some areas. If a beneficiary who was considering the plan requested information on the network primary care providers in the local area, the network list would not show any and the beneficiary would be unlikely to join. If this were the case, the plan would be hard-pressed to demonstrate it was serving the entire region. CMS needs to monitor the networks closely to ensure that the PPOs make a good faith effort to provide network providers across the entire region and should require that plans publish the names of providers that qualified for in-network cost-sharing along with other network details. Otherwise, regional plans might operate like local plans and only sign up providers in the most attractive areas, thereby discouraging enrollment in less desirable areas.

Subpart D–Quality Improvement Program

CMS asks for comments on whether it should require different types of plans to report comparable quality measures. The Commission acknowledges that PPOs do not currently report all HEDIS measures that are reported by HMOs. We think that the distinctions between HMOs and PPOs are blurring and that PPOs have improved their ability to collect this data. We believe that CMS should require uniform reporting of quality measures, with the acknowledgment that, according to the law, PPOs are only required to collect the measures related to services provided by network providers. Finally, we are disappointed that the MMA exempts MSA and PFFS plans from all quality data reporting requirements, even though those plans may require members to use a network of contracted providers.

Subpart F–Submission of Bids, Premiums, and Related Information and Plan Approval

No optional supplementals covering Medicare cost sharing

CMS proposes to prohibit plans from offering separately purchased add-on policies (optional supplementals) that would fill in any Medicare cost-sharing or lower Parts B or D premiums. CMS states several reasons supporting this policy including: Part D supplemental policies are prohibited in statute, and selling a policy that could affect Medicare service use by some (but not all) plan members would confuse the plan's bid for the basic Medicare benefits. Also, the rule would allow plans to offer supplemental policies that do not affect Medicare benefit use, such as dental or vision benefits. Plans could still offer a variety of comprehensive benefits through multiple packages.

MedPAC supports this choice because it would help the bidding process be more transparent and would not prevent plans from offering benefit choices.

Risk-adjustment of savings

CMS also asked for input on how to risk adjust the plans savings calculations upon which rebate amounts are determined. Under one alternative presented, the savings would be risk-adjusted in a plan-specific manner, meaning that the difference between the plan's bid and benchmark is multiplied by the risk-adjustment factor of its members to calculate the rebate it receives from Medicare. Thus, Medicare's payments and savings from each plan are proportionate to the difference between the plan's bid and benchmark. This risk-adjustment method would result in plans with sicker members getting more rebate money with which to fund supplemental benefits (or lower premiums) for their members.

The proposed rule voices the concern that this risk adjustment would mean that plans with the same bids in an area could get different rebates and be able to offer different premiums. If instead of risk-adjusting the savings, Medicare chose not to risk-adjust or to use a national or areawide average risk factor, plans who bid the same amount in the same area would get the same rebates. However, plans with relatively healthy beneficiaries would benefit disproportionately and if they attracted a healthy enough population they could even end up with payments higher than the benchmark.

The Commission supports the plan-specific risk-adjustment method. We believe that payments to plans should reflect both the efficiency of the plans and the health risk of their members. Plans with sicker members would need the extra funding to offer lower cost sharing because sicker members would have more cost-sharing liability. If instead of filling in cost sharing, plans use the rebates to lower the Parts B or D premiums, the plans with less healthy members would be able to offer lower premiums, which would serve to attract more healthy beneficiaries and move their overall risk back toward the average plan.

If CMS was concerned that too high a percentage of the rebates were inappropriately going to plans with high risk scores, it could create a corridor where a plan could not gain or lose more than a set percentage of rebates because of their risk score.

Subpart G–Payments to Medicare Advantage Organizations

Intra-area variation

Under the new bidding system, beginning in 2006, MA local and regional plans will submit bids that will be compared against benchmarks. The building blocks for the benchmarks are the current county-level payment rates. For local plans that submit a bid for a single county, the benchmark will be the county payment rate. If a local plan submits a bid for a multi-county area, the benchmark is defined in the MMA as the individual county rates in the area, weighted by the plan's enrollment in each county. The benchmark for the regional plans is defined as the individual county rates in the region, weighted by the number of Medicare beneficiaries in each county. Payments to a plan will reflect the plan's bid and the bid's relationship to it's benchmark. The MMA requires CMS to adjust payments to local and regional MA plans for variations in local payment rates within plan service areas. For 2006, CMS is considering how to adjust payments to an MA plan that has a service area larger than a single payment area (county or region).

It seems to us that the adjustment most consistent with the constraints of the MMA, and the most feasible to implement, is the county payment rates. MedPAC believes that there should be a level playing field for the different types of private plans. Because the different benchmarks are all built upon the county payment rates, and because the local

plans can always organize to be paid at the individual county level, payments to all the types of plans should reflect the county payment rates. Otherwise, spending on MA plans would likely increase under any geographic adjustment. CMS needs to monitor the bidding carefully to minimize any gaming that might occur. Over the longer run, the

Congress and CMS might consider a statutory change to the benchmark calculations to permit different adjustments in response to actual enrollment patterns; this will assure a level playing field between regional and local MA plans.

MedPAC appreciates this opportunity to comment on these proposed regulations. The Commission values the willingness of CMS staff to provide relevant data and to consult with us concerning technical policy issues.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Glenn M. Hackbarth,
Chairman