MEMORANDUM

TO: Senate Chronic Care Working Group

FROM: Better Medicare Alliance

DATE: October 30, 2015, 2015

RE: Revised Timeline for CMS Rate Notice

Thank you for inviting the Better Medicare Alliance to meet with on September 10, 2015. As the coalition representing the many stakeholders—plans, providers, senior service agencies, and beneficiaries, who support Medicare Advantage, we appreciated the opportunity to discuss the role of Medicare Advantage in improving chronic care in Medicare. You expressed particular interest in the issue that was raised regarding the need for greater transparency in policymaking in the Medicare Advantage (MA) program. MA's focus and the successful efforts in improving care coordination, early intervention, care transitions, and effective secondary interventions for seniors with chronic disease depend on a rational and open policymaking process. Greater transparency and understanding of policy making at CMS would improve the environment for innovative, transformative programs offered by MA.

In response to your request for more specific recommendations, we have developed a revised Timeline for CMS Rate. It is attached for your information and consideration. The recommendation is that the Senate Finance Committee consider policymaking in Medicare Advantage to be subject to regulatory guidance, rather than sub-regulatory guidance, and that announcements on STAR Ratings performance targets be prospective rather than retrospective. These two proposed changes would serve to significantly improve transparency, predictability, and deepen understanding of policy rationale among all stakeholders who are that are serving Medicare beneficiaries.

Problem Statement

As discussed during the meeting, the annual MA Call Letter was never meant to be a major policymaking document. It was intended for rate setting. In the absence of other policymaking vehicles, the Call Letter has become a policymaking mechanism for CMS. The sub-regulatory process has little transparency and a very short timeframe for feedback. The MA program covers almost 17 million Americans, at the cost of nearly $150 billion. yet the MA Call Letter allows only

14 days of comment on policy changes. In contrast, the Physician Fee Schedule in Medicare Fee-for-service allows 44 days, the home health rule allows 56 days, and the Accountable Care Organization (ACO) and quality rules allow 60 days.

Major policy making deserves longer feedback times, a requirement that feedback be made public, and that an impact analysis be provided by the agency. All of these goals can be accomplished by raising MA policymaking from sub-regulatory to regulatory guidance.

Existing MA Policymaking Timeline

Currently, under Section 1853(b) of the Social Security Act (enacted by the Medicare Modernization Act, or MMA), the Secretary of Health and Human Services is directed to provide an Advance Notice of Methodological Changes (referred to as the "Draft Call Letter") to Medicare Advantage plans at least 45 days before the Annual Announcement of Payment Rates ("Final Call Letter") is announced. Within this timeframe, stakeholders are typically provided two weeks to comment on the proposed changes. The Secretary is further required by statute to issue the Final Call Letter for the following calendar year not later than the second Monday in May in the previous calendar year.

For the Calendar Year (CY) 2016 Call Letter, this played out in the following sequential manner:

- February 20th, 2015: Advance Notice of Methodological Changes (Draft Call Letter) released, stakeholders two weeks to provide comments.
- March 6th, 2015: Stakeholder comments due to draft Call Letter.
- April 6th, 2015: Annual Announcement of Payment Rates (Final Call Letter) is released.
- June 1st, 2015: Bids are due for CY 2016.

Proposed Timeline

The Timeline revisions would require that Congress enact a formal regulatory process that allows more than two weeks for stakeholders to engage with CMS on major policy issues that have a meaningful and substantial effect on the quality of care available to Medicare beneficiaries. Specifically, major policymaking components of the Call Letter, like proposed risk adjustment guidelines, should be considered in a separate, formal Notice of Proposed Rulemaking (NPRM) with a standard 60 day notice-and-comment period. The NPRM should also incorporate the STAR Ratings request process, which currently is subject to only a 30 day comment period. This proposed NPRM would not disrupt the timelines as established under federal law for the Draft Call Letter and Final Call Letter. The NPRM would, however, respond to the growing complexity of the rate process for the MA program.

For example, the following timeline, given the proposed changes, for the CY 2018 would be:

- Early December 2016: NPRM on proposed risk adjustment and STAR Ratings request commences for CY 2018, providing stakeholders with 60 days to submit comments.

- Mid-February 2017: Comments to NPRM due.
- February 20th, 2017: Advance Notice of Methodological Changes (Draft Call Letter) released, providing stakeholders two weeks to provide comments.
- March 6th, 2017: Stakeholder comments due to draft Call Letter.
- April 7th 2017: Annual Announcement of Payment Rates (Final Call Letter) is released.
- June 1st, 2017: Bids are due for CY 2018.

Prospective Performance Measurement in STAR Ratings Program

In September of each year, CMS announces “cut points” that determine each MA plan’s STAR Rating for the following calendar year, on a scale from 1 to 5, 5 being the best. These performance measures are announced based on the previous year’s performance, and based on services already rendered. These performance measures have driven significant improvements in quality, enable public accountability, and result in bonus payments to plans, based on quality. These payments are used to invest in initiatives to further improve quality, service delivery, and enhance benefits that have a meaningful impact on beneficiaries’ health and well-being.

However, the timing of the release of proposed “cut points” impedes the ability of MA plans to fully realize improvements in plan performance because performance measures are released in October for the following calendar year, well after most provider contracts have already been executed. This situation makes it extremely difficult for MA plans to effectively calculate targets for the quality measurements determinant in achieving a high STAR rating. Setting performance measurements in a prospective manner would allow MA plans to integrate performance targets into value based contracts with providers, as well as enable the establishment of longer term, continuous quality improvement targets. To effectuate this change, it would be beneficial, beginning in September 2017, that “cut points” be established with prospective performance measures for CY 2019 and CY 2020, respectively. This timeframe would provide the time necessary for plans and providers to implement successful quality performance goals.

We hope that these proposals are helpful to the Committee’s Working Group and advances the goal of improvements in the care of those with serious chronic conditions. Please let us know if you have any questions. We would welcome further discussion of this revisions and their inclusion in proposed action by the Committee.