

March 1, 2013

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Mr. Jonathan Blum
Director, Center for Medicare
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via email to: AdvanceNotice2014@cms.hhs.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter (Advance Notice/Call Letter)

Dear Ms. Tavenner and Mr. Blum:

The 2014 Medicare Advantage (MA) reimbursement cuts envisioned by CMS in its Advance Notice/Call Letter would thwart CMS's mission: the cuts result in higher costs for millions of beneficiaries, diminish choice for Medicare enrollees, compromise the viability of the MA program and undercut Medicare Advantage's ability to deliver better quality at lower costs.

The 2014 Advance Notice/Call Letter proposes a *negative* MA Growth Percentage at a time when health care costs continue to rise. This 2.3 percent cut is the most severe MA Growth Percentage reduction since the introduction of the MA program. When combined with mandated reductions in MA reimbursement required by the Patient Protection and Affordable Care Act, 2014 MA payments will fall by approximately \$11 billion. This reduction equates to between \$600 and \$1,080 in higher costs for the average MA beneficiary each year.¹ The chronically ill, who use more health care services and often choose MA to assist in paying for them, will necessarily experience bigger cost hikes than the average beneficiary.

¹ Oliver Wyman, "Proposed Changes to 2014 Medicare Advantage Payment Methodology and the Effect on Medicare Advantage Organizations and Beneficiaries" (February 26, 2013).

Each year since 2009, MA Plans have absorbed payment cuts and growing medical costs largely through better care and cost management, lower profit margins, and the implementation of a star-ratings bonus demonstration program. There are, however, limits to the ability of Plans to cope with ongoing, steep reimbursement cuts while simultaneously improving the quality and care management available to Medicare Advantage members. The cuts in the Advance Notice/Call Letter cross the line and exceed those limits.

Sharp and dramatic rate cuts of this magnitude will prompt widespread upheaval in the MA market. None of the 14 million Medicare beneficiaries enrolled in MA will be unharmed. MA Plans will reduce their service areas, cut benefits, and severely narrow their provider networks, which will create disruption across the care delivery community. For those Plans that survive, the value to enrollees – wide selection of providers, access to care coordination and coverage for services that original Medicare does not provide – will evaporate in many markets. MA Plans will close, and many enrollees – certainly hundreds of thousands, and possibly millions -- will lose this coverage option altogether. Beneficiaries losing their MA Plans may be required to move back to the original fee-for-service (FFS) system, thereby losing access to MA's care coordination model that delivers fewer preventable hospitalizations, better access to primary and preventive care, improved quality, and more appropriate utilization of services.

We urge CMS to use the full extent of its authority to prevent this harm and disruption to Medicare beneficiaries in 2014 or Medicare Advantage's role as a partner to both Medicare and beneficiaries will cease.

We appreciate CMS's request of MA Plans for concrete steps the agency can take to address these challenges for 2014. Indeed, we believe CMS can and should take a number of steps to eliminate or mitigate the adverse impact of the Advance Notice/Call Letter on beneficiaries.

A summary of key comments and recommendations that we believe are the groundwork for CMS taking such steps follows.

UnitedHealth Group's Key Comments and Recommendations

Growth Rate: There is very little information available to MA Plans to evaluate CMS's trend assumptions, so we are not able to provide substantive comment on the growth rate or the underlying assumptions. The overall growth rate is significantly lower than expected, a drop that is largely driven by the significant favorable restatements in prior periods. Restatements of the magnitude contemplated by the Advance Notice/Draft Call Letter are rare. In the absence of additional information regarding the methodology and assumptions used in the Advance Notice, the complexity of these issues, and the impact on beneficiaries, we request that CMS look very closely at any changes in actuarial methodology from prior years and delay such changes until next year. We also request CMS exhaustively identify instances where the rates are a result of the exercise of policy and actuarial discretion and reconsider those choices for this year. In the meantime, in the

interests of transparency and clarity, we request that CMS provide MA Plans a full disclosure and explanation of the methodology and assumptions underlying the growth rate, so that there is an opportunity for careful analysis and thoughtful dialogue about the proposed changes, consistent with important procedural protections afforded to beneficiaries and those who serve them.

Recalibration and Risk Adjustment: CMS indicated the proposed change in the risk adjustment model is to address the difference in health care conditions coding between MA and original FFS. The purpose of the original MA coding intensity adjustment is to reflect the difference between MA and FFS coding intensity trend. This original coding intensity adjustment has already increased from 3.41% to 4.91% for 2014, as required by statute. However, it is not clear how CMS's new risk adjustment model is aligned – or, as the case may be, not aligned – with the 4.91% statutory coding intensity adjustment. This raises the possibility that CMS's new model may be seeking to correct the MA-FFS differential already accounted for in the statutory adjustment.

Our initial analysis of CMS's new risk adjustment model indicates that it will have the most significant impact on Plans with the most vulnerable populations, in particular chronic and dual SNPs. Appropriately recognizing the cost of treating these patients allows for Plans and providers to invest in clinical programs to supplement the endemic lack of resources experienced by these people, many of whom gain access to regular health care services for the first time with their entry into Medicare. We believe Plans with these most vulnerable beneficiaries could be impacted most negatively, resulting in even more instability in beneficiaries' coverage and perhaps fewer coverage options.

Broadly speaking, while UnitedHealth Group agrees with the policy objective underlying the risk adjustment system, the current system should be re-evaluated and replaced with a model that is both less onerous to administer and less subject to the vagaries of the volatile and unreliable fee-for-service system upon which it is based. Given these concerns and all of the other factors that cause tremendous uncertainty and reductions for beneficiaries for 2014, CMS should defer any changes to the CMS-HCC model.

Assuming the "Doc Fix" in Rate Calculation: The accurate determination of MA Plan payment rates, and the stability of these payment rates are critical to the MA program's success. The CMS methodology for determining MA Plan payments has not accounted for Congressional action to avert scheduled payment reductions under the Medicare Physician Fee Schedule. This affects the accuracy of CMS payments to MA Plans, the benefit packages available to Medicare beneficiaries and calculation of beneficiaries' financial responsibility. The absence of a long-term solution to the Medicare physician payment system has a direct effect on the 14 million beneficiaries in Medicare Advantage Plans. For every 5 percent reduction in physician rates, there is approximately a 1 percent reduction in MA rates. This results in unnecessary premium increases and benefit reductions for Medicare Advantage beneficiaries.

In the absence of a permanent legislative solution to the Medicare physician payment system, we strongly urge CMS, when calculating the final 2014 Growth Rate, to use its

existing authority and assume an actuarially sound estimate of change in the physician fee schedule to ensure that 2014 MA rates reflect the true, actual costs of paying providers under Medicare in 2014. We believe this is fully within the current authority of CMS and such action would be consistent with CMS's instructions to MA Plans for preparing their bids. This approach would align the assumptions that support MA Plans' bids and the benchmarks against which they are compared. *(See attached Legal Analysis conducted by SNR Denton.)*

Calculation of FFS Rates and Average Geographic Adjustment Methodology: CMS has indicated that it will be rebasing rates for 2014 as well as introducing changes to the calculation of the Average Geographic Adjustment methodology used to develop those rates. CMS has not provided any detailed information regarding the impact of such changes at this time; as a result, it is not possible to provide substantive feedback on the proposed changes. Given all of the other changes being proposed this year, we recommend that CMS exercise its discretion to postpone changes to the Average Geographic Adjustment methodology or rebased rates for 2014. Changes to the payment methodology should be considered with more time to provide input into the changes and to better understand the implications on clinical care and beneficiaries.

As always, UnitedHealth Group welcomes the opportunity for constructive discussion as part of this comment process, and look forward to sharing any additional data or information that supports beneficiaries, CMS and American taxpayers. We are committed to providing Medicare beneficiaries with stable access and affordable coverage, and ensuring that our Plans continue to facilitate good consumer decision-making, improve outcomes and quality, and provide excellent value to beneficiaries.

Sincerely,



John L. Larsen
Chief Executive Officer
UnitedHealthcare Medicare & Retirement