November 25, 2015

Cheri Rice, Director
Medicare Plan Payment Group
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Director Rice:

On behalf of Altegra Health, I am pleased to submit our comments on the memo from the Health Plan Management System (HPMS), "Proposed Changes to the CMS-Hierarchical Condition Category (HCC) Risk Adjustment Model for Payment Year 2017," dated October 28.

Altegra Health applauds CMS's recognition that the existing CMS-HCC model under-predicts the health care costs of full-benefit dual eligible Medicare Advantage (MA) beneficiaries and we fully support CMS's efforts to more accurately compensate MA plans for the care of these beneficiaries. However, we are concerned that the changes CMS proposes to the *partial-benefit* dual eligible model could have the unintended consequence of reducing enrollment in Medicare Savings Programs (MSPs), which help low-income MA beneficiaries pay Medicare premiums and cost-sharing. The Medicare Payment Advisory Commission (MedPAC) has expressed concern about the low percentage of eligible individuals who are aware of and enroll in these critical programs.[1] While MA plans are allies in CMS's efforts to increase enrollment in MSPs, reducing MA plan payments for partial-benefit dual eligible beneficiaries would reduce resources for MA plans to help these beneficiaries enrollment in MSPs. Therefore, we urge CMS to improve the accuracy of plan payments for full-benefit dual eligible beneficiaries, while preserving current payment levels for partial-benefit dual eligible beneficiaries.

This letter provides background information on MSPs and Altegra Health's role in helping MA low-income beneficiaries learn about and enroll in MSPs, as well as the harm to these efforts that could occur if CMS moves forward with its proposal to reduce payments for partial-benefit dual eligible beneficiaries.

In addition to Altegra Health's role in MSP eligibility, Altegra Health provides risk adjustment services to MA plans and therefore we also include technical and operational suggestions with respect to the proposed changes in the model.

[1] See, e.g., Medicare Payment Advisory Comm'n, *Dual-eligible Beneficiaries: Status Report on Current and Future Analytic Work* (2015); Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare and the Health Care Delivery System* ch. 4 (2014).

Background on Altegra Health

Altegra Health provides risk adjustment, quality, government program assistance, and advisory services to more than 150 MA, Medicaid, and commercial plans operating in all 50 states, as well as the District of Columbia and Puerto Rico. We also serve hospitals, Accountable Care Organizations (ACOs), and other healthcare providers.

The mission of Altegra Health is to help healthcare organizations and their members receive the financial resources and other benefits to which they are entitled, enabling quality care at the right time, leading to improved health at a lower cost, and overall, a better quality of life. Altegra Health utilizes health plan data and Altegra Health's proprietary predictive analytics algorithms to assist health plans in delivering integrated health-related interventions that are specifically tailored to their members. In carrying out this mission, Altegra Health is committed to maintaining the strictest regulatory compliance and data security for health plans and the members that they serve.

Concerns about MSP Participation

Low-income Medicare beneficiaries whose income or assets exceed state thresholds for full Medicaid benefits may be eligible for MSPs that help pay their Medicare premiums and cost-sharing. Eligibility criteria and benefits vary across the four MSPs (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), Qualified Disabled and Working Individuals (QDWI)). The Congressional Budget Office has estimated that only 33 percent of those eligible for the QMB program have enrolled, and only 13 percent of those eligible for the SLMB program have enrolled.[2] MedPAC, as well as the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC), have studied the issue and believe low participation may be due to lack of awareness of MSPs, the complexity of the application process for beneficiaries, and that the eligible population is hard to reach because of age, linguistic barriers, isolated location, or cognitive impairment.[3]

Low MSP participation concerns Congress, which has twice taken steps to address it, including by requiring the Social Security Administration (SSA) to notify low-income Medicare beneficiaries that they may be eligible for MSP benefits and by requiring SSA to transfer information about potentially eligible beneficiaries to the relevant state Medicaid agencies.[4]

Altegra Health's Role in Promoting MSP Participation

Current CMS payment policies encourage MA plans to identify those beneficiaries that are eligible but not enrolled in a MSP and help them obtain the benefits to which they are entitled. Many MA plans

[2] Medicaid & CHIP Payment & Access Comm'n, *Improving Enrollment and Eligibility for the Medicare Savings Programs* 3 (2015), https://www.macpac.gov/wp-content/uploads/2015/02/Improving-Enrollment-and-Eligibility-for-the-Medicare-Savings-Programs.pdf

[3] Medicaid & CHIP Payment & Access Comm'n, *Report to the Congress on Medicaid and CHIP* (2013); Medicare Payment Advisory Comm'n, *Report to the Congress on Medicare Payment Policy* ch. 5 (2008).

[4] Social Security Act §§ 1144, 1935(a).

contract with Altegra Health to perform this important work. The low enrollment figures for MSPs demonstrate how critical it is to have resources dedicated to facilitating these enrollments.

Altegra Health uses a proprietary predictive analytics model to determine the likelihood that MA low-income beneficiaries will be eligible for MSP. Altegra Health's model has historically been extremely successful in identifying these beneficiaries, with an accuracy rate consistently over 95 percent. After applying its predictive analytics, Altegra Health outreach staff helps these beneficiaries submit their enrollment applications. Altegra Health reaches out to these beneficiaries through mailings and phone calls to educate them about MSP and its benefits.

Interested low-income MA beneficiaries can then choose to utilize Altegra Health's My Advocate™, an internet-based eligibility screening tool that helps these beneficiaries enroll in these programs. An Altegra Health outreach worker can also walk the beneficiary through the MSP application and assist with every step necessary to complete it. The beneficiary can choose to designate Altegra Health's outreach staff as his or her authorized representative in order to submit the application on his or her behalf and address any issues that surface as the application is evaluated by the state Medicaid agency.[5] Finally, Altegra Health reaches out to enrolled MSP beneficiaries annually to assist with the renewal of their MSP benefits if they still qualify.

Altegra Health devotes significant resources to understanding the MSP eligibility criteria and process in each state. As the enrollment figures show, without this experienced adviser, enrollment in these programs can be challenging. In 2014, Altegra Health helped more than 50,000 MA low-income beneficiaries enroll in MSP. Overall, Altegra Health has helped beneficiaries secure $1.9 billion in Part B premium savings.

Altegra Health also links MA low-income beneficiaries with other programs from which they may benefit such as the Part D Low Income Subsidy (LIS) and can help them apply. Altegra Health's COMMUNITY Link™ product can help beneficiaries learn about and enroll in more than 10,000 public and privately-sponsored community programs, including for nutritional and energy assistance. These benefits positively impact a beneficiary's overall health and well-being. Furthermore, we have seen that beneficiaries receiving MSP, LIS, or community and social supports are more likely to be satisfied with their MA plan and the Medicare program.

Comments on the Proposed Changes to the Risk Adjustment Model

Impact on Payments for Full-Benefit Dual Eligible Beneficiaries

Altegra Health fully supports CMS's commitment to improve payments to plans that enroll full-benefit dual eligible MA beneficiaries. CMS's own analysis shows that the current CMS-HCC model predicts only 91.4 percent of the actual cost of full-benefit dual eligible beneficiaries. Dual eligibles account for 34 percent of Medicare spending, despite consisting of only 20 percent of the Medicare population.[6]

[5] See 42 C.F.R. § 435.923

[6] MedPAC & MACPAC, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, http://medpac.gov/mwg-internal/de5fs23hu73ds/progress?id=ixdovkoBKBAMwA9497ViR4Mct9JyPUaOLkLnlGcl-SE,&dl (2015).

Management of the chronic and acute care needs of this population is a key to improving care, population health, and reducing costs. MA plans can be partners in this effort but they will lack the resources to do so if they are being paid only 91.4 percent of the cost of providing care.

Impact on MSP Enrollment Efforts

Altegra Health believes that reducing payments to MA plans to enroll partial-benefit dual eligible beneficiaries into MSPs will adversely impact these beneficiaries. At a time when Congress, MedPAC and MACPAC have expressed serious concerns about the accessibility of MSP, reducing plan payments for this population would further reduce enrollment by discouraging MA plans from conducting the resource-intensive outreach and assistance necessary to help their beneficiaries obtain these benefits. Without these critical plan payments, potential MSP beneficiaries will needlessly face higher Medicare premiums and cost-sharing, likely resulting in fewer resources for beneficiaries to use on essential items such as food, rent, or other healthcare costs. They may also forego needed medical care as a means to avoid deductibles and other cost-sharing obligations in the absence of MSP enrollment.

Maintaining payments for partial-benefit dual eligible beneficiaries is critical to ensuring that these beneficiaries have access to the care and resources they need to remain healthy. Given the relatively small proportion of low-income seniors and people with disabilities who are partial-benefit dual eligible beneficiaries, the financial impact on the Medicare program as a whole of maintaining current payment levels should be relatively small. Additionally, preserving payments will have an immediate and significant impact on the lives of these beneficiaries.

Finally, in the current payment model, the additional incremental cost of caring for partial-benefit dual eligible beneficiaries and assisting them in the MSP eligibility process is captured in the Medicaid add-on factor, whereas in the revised model, we understand that population-specific costs would be captured entirely in HCC coefficients. Altegra Health is concerned that this shift to an HCC-driven model will reduce overall payments resulting from uneven and inadequate risk scores. Risk scores are dependent upon provider documentation and billing and health plan data submission via the Risk Adjustment Processing System (RAPS) and the Encounter Data System (EDS). Insufficient documentation or data submission errors can reduce risk scores, which will now affect the adjustment for Medicaid status. The CMS analysis could not account for this factor since fee-for-service (FFS) data was utilized. To compensate, MA plans will need to invest additional resources to identify and correct inadequate risk scores. This potential decreased payment and additional expense may further reduce resources for MA plans to identify and enroll beneficiaries in MSPs and LIS.

Operational and Technical Comments

- Waiting until the 2017 Advance Rate Notice in February to release the revised CMS-HCC model does not give MA plans sufficient time to analyze the impact of the revised model and give CMS meaningful feedback. Furthermore, MA plans need significant advance notice of changes to the CMS-HCC model in order to correctly prepare their bids. Altegra Health encourages CMS to release the full model as soon as possible, and to include the SAS code in this release, as CMS has done for the commercial risk adjustment model. Direct access to the SAS code will reduce

the time it will take MA plans to evaluate the impact of the change, allowing CMS to receive meaningful comments and bids that are priced accurately.

- Because CMS proposes to move to a concurrent model, the model will need to address additional eligibility issues. Altegra Health's experience enrolling and re-enrolling MA low-income beneficiaries have shown that there is significant variability in the amount of time state Medicaid agencies take to process beneficiary applications. CMS should review its proposed changes to ensure that MA plans are paid accurately for the months that a beneficiary is enrolled in a MSP, particularly when an application is processed with retroactive benefits and there is a delay in the data reaching CMS from the state. We recommend that CMS create clear tracking for payment adjustments and allow for the possibility that payment adjustments could occur after the final sweeps deadline resulting from Medicaid retroactive status and delays in state reporting.
- CMS should clarify whether it intends to make any changes to the payment timing for the Institutional, End-Stage Renal Disease (ESRD) and New-to-Medicare models. Specifically, CMS should clarify whether these models will continue using the current Medicaid add-on factor with base payment derived from the base year rather than the concurrent year. If so, we are concerned that managing payments for two different methodologies could be very complicated, especially because beneficiaries can move between the models. Therefore, we recommend that CMS adjust the payment methodology to be consistent for all risk models, either prospective or concurrent.
- The October 28 HPMS memo does not explain how the revised model will account for MA enrollees without HCCs; Altegra Health encourages CMS to explain.

Conclusion

Altegra Health appreciates the opportunity to share its experience helping MA low-income beneficiaries enroll in MSPs. We urge CMS to consider the impact of changes to the HCC model that will result in reduced resources to help these beneficiaries gain access to programs to which they are entitled. Please feel free to reach out to me or our team if we can be of further assistance.

Sincerely,

Kevin C. Barrett
President & CEO