CHANGE HEALTHCARE

Date 03.02.18

Demetrios Kouzoukas

Principal Deputy Administrator and Director, Center for Medicare

Centers for Medicare & Medicaid Services (CMS)

7500 Security Boulevard, Baltimore, MD 21244

Dear Director Kouzoukas,

On behalf of Change Healthcare, I am submitting comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter.

Change Healthcare is inspiring a better healthcare system. Change Healthcare is a key catalyst of a value-based healthcare system – working alongside its customers and partners to accelerate the journey toward improved lives and healthier communities. While the point of care delivery is the most visible measure of quality and value, Change Healthcare is a healthcare technology solutions company that uniquely champions the improvement of all the points before, after, and in-between care episodes. With its customers and partners, Change Healthcare is creating a stronger, better coordinated, increasingly collaborative, and more efficient healthcare system that enables better patient care, choice, and outcomes at scale.

Change Healthcare's comments below include details about the products and services for MA plans and the beneficiaries they serve.

Ensuring coverage for MA dual eligible beneficiaries

Change Healthcare is deeply committed to ensuring that all MA beneficiaries have the appropriate access to medical coverage. Change Healthcare identifies MA low-income beneficiaries who may benefit from dual enrollment and acts as an authorized representative to assist them in applying to the appropriate state Medicaid agency. Change Healthcare routinely provides enrollment assistance on behalf of plans who provide benefits to more than 50 percent of the total MA population. Change Healthcare annually assists to enroll approximately 44,000 MA low-income beneficiaries in a dual eligible program and has cumulatively helped save these beneficiaries over $2.5 billion in Part B premiums since this business's inception.

Change Healthcare commends CMS for encouraging MA plans to inform providers about their enrollees who are qualified Medicare beneficiaries (QMBS) and their exemption from Medicare cost-sharing requirements. While the Advance Notice states that CMS's Medicare Advantage Medicaid Status Data File (MCMD) "provides the most current information about monthly dual status," Change Healthcare is concerned that this data file has gaps and inaccuracies that undermine MA plan efforts to inform providers about all levels of dual eligible status. Further, the data gaps inhibit Change Healthcare to effectively help QMBs and other dually eligible MA beneficiaries gain and renew Medicaid eligibility. Change Healthcare urges CMS to meet with its experts and remedy the shortcomings of this data file.

Change Healthcare commends CMS for acknowledging the unintended consequences for MA

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beneficiaries to gain and renew Medicaid eligibility in previous proposals. In June 2016, CMS's proposed technical guidance regarding the implementation of the 2017 CMS-HCC risk adjustment model would have provided Change Healthcare with only two points in time annually to review current Medicaid status. After Change Healthcare met with CMS to discuss these concerns in August 2016, CMS indicated it would revise its earlier guidance. Change Healthcare commends CMS for including MA beneficiary Medicaid status in the previous three months as part of the Monthly Membership Report (MMR) beginning in July 2017.

In addition to the MMR, CMS began sending the MCMD to MA plans in April 2017 for May 2017. Change Healthcare has reviewed these reports and notes the following data anomalies in the MCMD:

- Some dual eligibles indicated in the MMR are missing from MCMD files: MCMD files appear to only include new dual eligibles on or after the January 2017 run date. As a result, those who became dually eligible prior to that run date are missing from the MCMD in files reviewed through August 2017.Though this may have been intended in CMS's implementation, this decision to not include those dual eligibles enrolled before January 2017 prevents Change Healthcare from assessing dual eligible status before 2017, which is still relevant for final MA reconciliation payments.
- The MCMD information is not current in relation to the MMR: Change Healthcare can provide examples of MA dual eligibles who appeared on MMR files one month prior to when they appeared on the MCMD files. Because the MCMD file is generated just one day prior to the MMR, both of which are provided to MA plans at the same time, there is no significant information provided in the MCMD that will aid the enrollment assistance process, particularly as the MMR data is one day more current than the MCMD for a given month.
- The Medicaid End Date field is not aligned with Medicaid Dual Status End Date: The Medicaid status end date on the MCMD file remains unpopulated despite the loss of Medicaid. Change Healthcare can provide examples where no other row exists demonstrating a change in dual status.
- True Medicaid and Dual Status Start Dates are unknown: The majority of MCMD Medicaid and Dual Status Start Dates are defaulted to January 1, 2017. Change Healthcare requests a MCMD reconciliation to provide accurate start dates.
- State aid code: Change Healthcare has met with CMS in the past to request that states provide CMS with more detailed information about the Medicaid eligibility pathway and state aid category, as the detail needed to identify beneficiaries who are required to complete an annual Medicaid review cannot be obtained via dual status code. In § 1634 states, Supplemental Security Income (SSI) cash recipients automatically qualify for Medicaid and therefore are not required to complete an annual Medicaid renewal with their state Medicaid agency. Change Healthcare seeks a mechanism to identify SSI cash recipients in § 1634 states so that it can exclude them from enrollment assistance outreach and focus resources on beneficiaries who are required to complete an annual review to maintain their Medicaid eligibility.

Change Healthcare notes it has contacted CMS and provided examples of these data anomalies to its Information Technology Help Desk in August 2017. To date, CMS has not

responded to these requests for assistance.

Similar to the concerns expressed to CMS in August 2016, in order to predict when a MA beneficiary will be required to complete an annual renewal, Change Healthcare and the MA plans it serves need the actual Medicaid effective date through the MCMD in order to effectively assist Medicare beneficiaries. In addition, in order to minimize lapses in Medicaid coverage, more timely information about loss of Medicaid eligibility is required so that Change Healthcare can assist beneficiaries with late renewals and/or assist with re-application. The MCMD and MMR files do not reflect a loss of Medicaid eligibility and dual status until at least three months after eligibility ended. At this point, beneficiaries are required to re-apply because it is too late to complete their renewal, and as a result, most will have a gap in their Medicaid coverage. Coverage gaps have a significant financial impact on this vulnerable population and can also impact their continuity of care if they are disenrolled after their Medicaid eligibility ends. Change Healthcare notes that those enrolled in special needs plans for dual eligibles (D-SNPs) could also be impacted if the plan does not have accurate information to maintain Medicaid eligibility for those who qualify.

Change Healthcare respectfully requests to meet with CMS MA leadership to discuss these issues so that it can continue to assist MA low-income beneficiaries with maintaining their enrollment into Medicaid. This will ensure that MA plans have the resources to effectively serve this vulnerable, high-need population.

CMS-HCC Risk Adjustment Model

Change Healthcare works closely with MA plans to ensure that they obtain accurate risk scores for their beneficiaries and supports policies that strengthen risk adjustment programs. Change Healthcare's services begin with proprietary technology and expertise to assist MA plans in converting their source data and managing errors to facilitate timely and accurate submission to the Risk Adjustment Processing System (RAPS) and Encounter Data System (EDS). Change Healthcare adds proprietary technology and analytics that are utilized by MA plans to evaluate the documented health status of their beneficiaries, identifying gaps between health status, provider documentation and reported quality scores and risk scores.

Change Healthcare supports the addition of HCCs accounting for mental health and substance use disorders, as well as chronic kidney disease. This work will enable MA plans to better serve its beneficiaries with chronic conditions.

Change Healthcare also supports the Payment Condition Count Model, which will account for the total number of diseases or conditions of an MA beneficiary. Change Healthcare does not support the All Condition Count model because it would create considerable additional provider medical record documentation burden.

Change Healthcare notes the complexity of implementing the proposed 75-25 blend of RAPS and EDS risk scores utilizing different models and sources to data. While blending has occurred in past years, the blending occurred with a consistent data source and a consistent source model. Combined with the challenges associated with the release of multiple versions of the MAO-004 reports, Change Healthcare believes that consistent application of risk adjustment models and methodologies would ease the administrative burdens to MA plans and actuaries caused by the proposed blended model.

Change Healthcare supports the use of Health Risk Assessments (HRAs) in Rewards and Incentives Programs. The information uncovered through a HRA can be invaluable towards having a wholistic view of a MA beneficiary so that his/her plan can better utilize its resources to manage his/her health and well-being.

Star ratings measure changes

Change Healthcare partners with MA plans in several unique ways to meet their Healthcare Effectiveness Data and Information Set (HEDIS®), Star ratings and other quality reporting needs to better manage beneficiaries' overall care. Change Healthcare's HEDIS.com software and industry-leading expertise enable MA plans with full command over the management of their HEDIS and quality measure reporting and workflow processes. Change Healthcare solutions feature a full, web-based, end-to-end approach for all quality and clinical outcomes reporting.

Change Healthcare supports changes to the improvement measures; this will help MA plans measure their improvements more effectively. Increased transparency on the improvement measures will help MA plans to better assess how they are improving the delivery of care to their beneficiaries. Change Healthcare supports the earlier release of prior year standard errors, which would help MA plans to better measure their improvements in care in relation to the rest of the MA plan market.

Change Healthcare supports a scale for Star ratings reductions due to appeals submitted to the Independent Review Entity (IRE). Currently, CMS relies solely upon audit data from the IRE submitted on four appeals measures to determine if MA plans have data mistakes. If there are data mistakes, the MA plan automatically is rated 1 for the measure. With this change, CMS will be utilizing a more statistical method to reduce the Star ratings for the MA plan. Instead of an automatic 1 star for data mistakes, MA plans will receive a reduction based upon how widespread inaccurate and deficient data exists. This is noteworthy because it aims to separate MA plans whose data quality has widespread deficiencies from those plans who inadvertently utilize mistaken data.

Star ratings and the Categorical Adjustment Index (CAI)

Change Healthcare supports the continued use of the interim CAI. Change Healthcare recommends that the CAI account for dual eligible status, as well as the Part D Low-Income Subsidy (LIS) and disability status. Lastly, Change Healthcare urges CMS to develop a long-term solution that addresses the socio-economic challenges faced by MA low-income beneficiaries.

In addition to assisted dual eligible enrollment, Change Healthcare helps identify and enroll MA low-income beneficiaries into the Part D LIS, as well as Community Link™, an extensive database of more than 15,000 public and privately-sponsored community programs to which they may qualify. Change Healthcare helps plans' low-income enrollees secure approximately $150 million in financial benefits through Community Link annually.

The strongest evidence of the positive impact of Change Healthcare's assistance to MA low-income beneficiaries is plan tenure. While the average period of MA plan enrollment is approximately three years, Change Healthcare finds that those it helps enroll into Medicaid as a dual eligible remain with their MA plan an additional 18 months. Similarly, Change Healthcare finds that those it helps enroll into a community-based program remain with the MA plan an additional 9 months. Thus, MA low-income beneficiaries stay more loyal to their plan when their

socio-economic challenges are addressed. Additionally, Change Healthcare finds that MA low-income beneficiaries express more satisfaction with their plan through a multitude of surveys that impact the plan's quality-based bonus payments when their socio-economic challenges are addressed.

Change Healthcare strongly urges CMS to incentivize MA plans and providers to meet the socio-economic challenges of their low-income beneficiaries through quality measures, program incentives or value-based care programs. Change Healthcare's experience has shown that its interventions with these beneficiaries have been linked to higher quality care, improved health, and lower costs.

Continuing its work to assess the impact of addressing socio-economic challenges, Change Healthcare is beginning to assess a new tool called the Patient Activation Measure (PAM).[1] The PAM is a survey that assesses an individual's knowledge, skill, and confidence for managing his/her health and health care. Scores are aggregated into four categories; higher categories have been shown to indicate improved control of chronic conditions with improved health levels and lower costs of care. Change Healthcare will be conducting a study utilizing the PAM among select MA plan clients and their beneficiaries who have received enrollment assistance into programs that address their socio-economic challenges.

Supplemental benefits

Change Healthcare supports the proposal for MA plans to offer supplemental benefits if they compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization. Change Healthcare urges CMS to include services in this category that address socio-economic challenges. As noted above, Change Healthcare's enrollment assistance programs have been linked to higher quality care, improved health, and lower costs.

Conclusion

Change Healthcare appreciates the opportunity to comment on the Advance Notice. Please contact me (tim.jones@altegrahealth.com) if you have any questions or would like to arrange a follow-up meeting to discuss any of these issues in further detail.

Sincerely,

Tim Jones

Tim Jones
Director, Public Policy & Advocacy

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[1] Hibbard, Judith H., et al. "Development of the Patient Activation Measure (PAM): Conceptualizing and measuring activation in patients and consumers." Health services research 39.4p1 (2004): 1005-1026.