



March 5, 2018

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**RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the
Medicare Advantage Risk Model; Advance Notice of Methodological Changes for Calendar
Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D
Payment Policies; 2019 draft Call Letter**

Dear Mr. Kouzoukas and Ms. Lazio:

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on Parts I and II of the Advance Notice for Calendar Year (CY) 2019 for Medicare Advantage and Part D and the CY 2019 draft Call Letter. AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation.

Approximately 20 million Americans, or about one third of all Medicare beneficiaries, have chosen to enroll in the Medicare Advantage program. Enrollment has increased by 8 percent in the last year alone and by more than 70 percent since 2010. Nearly 44 million seniors and individuals with disabilities are covered under Part D, with close to 18 million receiving their benefits through a Medicare Advantage plan and more than 25 million through a stand-alone Prescription Drug Plan (PDP).

Our members are committed to serving Medicare beneficiaries under the Medicare Advantage and Part D programs. These programs are critical to achieving national policy goals for an improved healthcare delivery system. Medicare Advantage plans lead the way in advancing innovative, patient-centered programs that improve care, reduce beneficiary costs, and address the needs of low-income and other vulnerable individuals. Part D plans have been a model of consumer choice and market competition that have improved access to prescription drugs and reduced out-of-pocket costs for tens of millions of beneficiaries.

We strongly agree with CMS that these programs have demonstrated the value of private sector innovation and creativity. We commend your commitment, as reflected in this Advance Notice and draft Call Letter as well as in the recently-proposed CY 2019 policy and technical regulation, to program improvements that enhance innovation, transparency, flexibility, and

simplification. In our comments, we highlight proposals in the Advance Notice and draft Call Letter that will promote these goals, such as provisions relating to benefit flexibility and the Star Ratings program.

In addition, our comments raise some significant concerns and offer recommendations on other issues that can affect the continued stability and growth of the Medicare Advantage program. Key areas of concern include several technical issues relating to the calculation of risk scores; certain components of a proposed change to the risk adjustment model that requires further consideration; the absence of an adjustment in benchmark calculations recommended by the Medicare Payment Advisory Commission (MedPAC) that we believe is appropriate under the Social Security Act; and a proposed reduction in payments for retiree plans.

These key issues are further summarized below and are discussed in detail along with other issues in the attached comments.

The Value of Medicare Advantage

Medicare Advantage plans offer a different approach to care delivery. Unlike the Medicare fee-for-service (FFS) program, Medicare Advantage plans implement programs that integrate and coordinate care, and effectively help patients prevent, detect, and manage chronic conditions. In addition, while the benefit package in the Medicare FFS program is largely stuck in time, reflecting its 1960s origins, Medicare Advantage plans often provide a more comprehensive benefit package. Additional valuable benefits may include vision, dental, and hearing coverage. Many plans also offer drug coverage at no additional cost to enrollees. And unlike Medicare FFS, the financial stability of Medicare Advantage enrollees is protected by annual out-of-pocket caps on their costs.

Medicare Advantage plays a crucial role in enhancing the delivery of high quality care. A recent peer-reviewed study found that on average, Medicare Advantage provides “substantially higher quality of care” by outperforming Medicare FFS on 16 out of 16 clinical quality measures, and achieving equivalent or higher scores on five out of six patient experience measures.¹ Another recent study found that value-based care in Medicare Advantage has resulted in lower costs while improving survival rates.² In other studies, Medicare Advantage has proven to reduce hospital readmissions and institutional post-acute care admissions while also increasing

¹ Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.

² Mandal, Alope K., Tagomori, Gene K., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

rates of annual preventive care visits and screenings.^{3,4,5,6} Further, the Medicare Advantage program has a beneficiary satisfaction rate of 90 percent for plans, preventive care coverage, benefits, and choice of provider.⁷

Medicare Advantage has also proven to be cost-effective. For many years, average plan bids for delivering the basic Medicare benefit have been well below Medicare FFS costs. Further, in 2018, average payments to Medicare Advantage plans will be roughly equivalent to Medicare FFS costs, according to MedPAC.⁸ Moreover, in many geographies with high Medicare Advantage enrollment, spending in the FFS program actually goes down as providers adopt practice patterns and care guidelines that “spillover” into their care of patients who remain in FFS Medicare.⁹ In fact, Medicare Advantage plans pioneered many of the FFS payment and delivery reform efforts that CMS has undertaken.

Key Areas of Support

AHIP and our members support many provisions in the Advance Notice and draft Call Letter, including:

- **Regulatory Proposals that Promote Benefit Design Flexibilities.** The draft Call Letter references certain provisions included in CMS’s recently proposed CY 2019 policy and technical regulation, including flexibility to offer value-based designs, that we strongly supported in our comments on the proposed rule.
- **Expanded Supplemental Benefits.** CMS proposes to expand, beginning in 2019, the scope of benefits that Medicare Advantage plans can offer as supplemental benefits. Under the CMS proposal, these benefits may now include items or services that can help plans diminish the impact of injuries or health conditions and reduce avoidable emergency and health care utilization.
- **Star Ratings Improvements.** CMS’s proposal to convene a technical expert panel addressing key structural, policy, and operational matters in the Star Ratings program is an important step for ensuring transparency, predictability, and stakeholder engagement.

³ Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.

⁴ Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S., et. al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Affairs* 34(1): 11-20. January 2015.

⁵ Ayanian, John Z., Landon, Bruce E., Zaslavsky, Alan M., et al. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare. *Health Affairs* 32(7):1228-1235. July 2013.

⁶ Lemieux, Jeff Sennett, Cary Wang, Ray, et al. Hospital readmission rates in Medicare Advantage plans. *American Journal of Managed Care* 18(2): 96-104. February 2012.

⁷ Morning Consult National Tracking Poll. March 11-16, 2016.

⁸ Medicare Payment Advisory Commission. Medicare Advantage program: Status report [presentation]. December 8, 2017.

⁹ Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.

We also support proposals that would address data submission problems in four appeals measures through scaled reductions in scores (rather than automatic full reductions), and that would remove a measure based exclusively on compliance and enforcement activities for 2019. However, for methodological and other reasons we believe additional steps should be taken to de-link agency audit and enforcement activities from the Star Ratings program. We also continue to encourage improvements to Star Ratings to better address the effects of socioeconomic status.

- **New Diagnosis Codes for Risk Adjustment.** We support the inclusion of diagnosis codes related to mental health, substance use disorders, and stage 3 of Chronic Kidney Disease in an updated risk adjustment model CMS has proposed. However, as noted below, we have concerns with an additional component of the proposed updated model relating to an individual's number of conditions.
- **Puerto Rico Relief.** We welcome the agency's willingness to continue certain policies of importance to plans covering Medicare beneficiaries in Puerto Rico. We also urge CMS to continue its adjustment to reflect the larger proportion of FFS Medicare beneficiaries in Puerto Rico who have zero claims compared to other parts of the United States. In addition, we urge CMS to consider further adjustments in payments to address the significantly lower benchmark rates in Puerto Rico.

Key Policy Concerns

AHIP and our members have significant concerns with several policies, such as:

- **Normalization Factor.** As noted in a recently-released report by Oliver Wyman¹⁰, payment levels under the Advance Notice on average will not keep pace with expected cost trend. A primary reason is a technical adjustment that would reduce 2019 risk scores by 2.3 percent through the FFS normalization process. AHIP is concerned that the increased normalization factor is larger than appropriate by over-adjusting for a small number of recent years of FFS risk scores that use ICD-10 codes. We urge CMS to include more data years in the normalization factor to minimize inappropriate reductions in payments.
- **Expanded Use of Encounter Data.** CMS proposes to increase the percentage of risk scores derived from diagnoses reported through the encounter data system from 15 percent in 2018 to 25 percent in 2019. The Advance Notice also suggests that the blend of diagnoses from encounter data will be increased pro rata over the ensuing three years (in step with the phase-in of a newly proposed risk adjustment model). Consequently, in 2022, encounter data diagnoses would generate 100 percent of risk scores. AHIP continues to have very significant concerns about the expanded use of encounter data given the unresolved operational issues that prevent CMS from generating complete and accurate risk scores and CMS's open acknowledgement that expanding the use of

¹⁰ Giese, Glenn, Sober, Josh, Fitzpatrick, Randall. 2019 Advance Notice: Changes to Medicare Advantage payment methodology and the potential effect on Medicare Advantage organizations. Oliver Wyman. February 2018.

encounter data will reduce payments.^{11,12} We appreciate certain steps that CMS has taken to respond to these concerns (including extended deadlines for submitting data and proposing to let plans supplement certain data), but these proposals are not enough. In our detailed comments, we include a number of recommendations, including requiring that encounter data be accurate and complete before increasing its use, rather than relying on an arbitrary schedule; ensuring plan risk scores are not negatively impacted by the use of encounter data through any phase-in period; and adjusting payment year 2016 and 2017 risk scores given such scores have been calculated based on data that is not accurate, transparent, or tested.

- **Coding Intensity Adjustment.** We support CMS’s proposal to use the statutory minimum coding intensity adjustment for 2019. However, we are extremely concerned by the suggestion in the Advance Notice that CMS is considering alternative approaches that could significantly increase the coding intensity adjustment. We believe the description of the approaches is too limited and uncertain to allow the agency to make any adjustment for 2019. Regardless, we strongly urge CMS to reconsider any such exploration of alternative methodologies given their adverse impacts on the premiums and benefits of 20 million Medicare Advantage enrollees. We also note that certain approaches raise serious statutory questions to the extent they limit the use of medical conditions in establishing risk scores.
- **Risk Model Changes.** As noted above, we support the inclusion of certain diagnoses in the risk adjustment model for 2019. However, we are concerned about the impacts of another component that CMS proposes to include in 2019 – an adjustment for the number of beneficiary conditions. An analysis by Oliver Wyman suggests that a model incorporating this change would lower risk scores for large numbers of Medicare-Medicaid “dual eligible” beneficiaries and have other impacts that require further consideration, including raising payments for individuals with no reported health conditions.¹³ Therefore, we recommend that CMS delay the implementation of its proposal to adjust for the number of conditions until 2020, so CMS and Medicare Advantage organizations can work together to better understand the impacts and explore alternatives. We also believe the phase-in of the new risk model should not be tied to the increased use of encounter data. In addition, we are concerned that CMS proposes to recalibrate the risk model for enrollees with end-stage renal disease (ESRD) using data that is being updated for the first time in many years. Our analysis indicates large swings in some risk scores that could be disruptive for plans and their members. CMS should mitigate these adverse impacts by phasing in the changes to the ESRD model.

¹¹ Centers for Medicare & Medicaid Services. 2019 Medicare Advantage and Part D Advance Notice Part II and draft Call Letter [Fact Sheet]. 1 February 2018. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-02-01.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>

¹² Department of Health and Human Services. Putting America’s health first: FY2019 President’s Budget for HHS. Available at: <https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf>

¹³ Giese, Glenn, Sober, Josh, Fitzpatrick, Randall. 2019 Advance Notice: Changes to Medicare Advantage payment methodology and the potential effect on Medicare Advantage organizations. Oliver Wyman. February 2018.

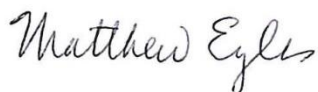
- **Benchmark Calculation.** In connection with the 2018 Advance Notice, AHIP recommended that CMS calculate benchmarks using only individuals enrolled in both Medicare Part A and Part B – and exclude individuals enrolled in Part A only. This approach would be consistent with a recent MedPAC recommendation and reflects the fact that beneficiaries enrolled in Part A only are ineligible to participate in Medicare Advantage plans. While CMS does not address the issue in the current Advance Notice, we continue to believe it is the appropriate approach to calculate benchmarks as a policy matter. Moreover, as reflected in the attached legal analysis by Epstein Becker & Green, P.C., we believe CMS should use this approach based on a plain reading of the Social Security Act. We urge CMS to address this issue in the Final Notice.
- **Employer Group Waiver Plans (EGWPs).** Approximately 4.1 million Medicare beneficiaries are enrolled in EGWPs. These products provide individuals with a seamless transition to retiree coverage that is more consistent with the benefits they received as active workers. We reiterate our opposition to the EGWP payment policy changes that CMS began to implement for 2017, which CMS proposes to complete in 2019, because of the adverse impacts on benefits and/or premiums. However, we strongly support CMS considering a change to its bid-to-benchmark calculation methodology under the new payment approach to reflect the enhanced use of Preferred Provider Organizations (PPOs) in EGWPs. If CMS continues with the payment policy, we recommend that CMS make an adjustment to reflect the new methodology, in addition to maintaining the current blend, so the effects of this change can be assessed.

Detailed Comments

Our attached comments cover a range of areas, including but not limited to the issues identified above and issues specific to Part D. Our recommended changes for the Final Rate Notice and Call Letter are aimed at maintaining a strong and stable Medicare Advantage program that allows plans to continue innovating and working with providers on transforming the health care system. The changes will ensure millions of seniors and individuals with disabilities continue to receive the high quality, coordinated care they rely on through Medicare Advantage.

We look forward to providing any additional information you may need and to continuing to work together to improve the health of the beneficiaries our members serve.

Sincerely,



Matthew Eyles
Senior Executive Vice President &
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Mark Hamelburg
Senior Vice President
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AHIP Detailed Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage Risk Model & 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

March 5, 2018

CY 2019 Medicare Advantage Risk Model

On December 27, 2017, CMS published Part I of the Advance Notice, which includes proposed changes to the Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) Risk Adjustment Model for 2019.

The new risk model includes the following proposed changes:

- Additional diagnosis codes related to mental health and substance use disorders
- An additional diagnosis code measuring the severity of chronic kidney disease
- An adjustment to the model that measures the number of diseases or conditions of an individual

Additional Diagnosis Codes

AHIP supports the addition of the additional diagnosis codes for mental health and substance abuse, and the addition of a diagnosis code for chronic kidney disease, stage 3. We believe the additional diagnoses will improve the payment accuracy of the model for these conditions.

Adjustment for Number of Conditions

CMS presents two options to account for the number of conditions or diseases of an individual, as required by the 21st Century Cures Act. Under one option, called the Payment Condition Count (PCC) model, CMS would only include payment HCCs to determine the count of diseases or conditions. Under the second option, called the All Condition Count model, CMS would include all HCCs, including those not used for payment, to determine the count of diseases or conditions. According to CMS's fact sheet that accompanied the proposed changes to the risk model, the All Condition Count has considerable variability around the risk score as compared to the PCC. While the average risk score difference may be similar between the two models, as CMS notes on page 21, the variability in risk score differences across plans suggests that the All Condition Count model would be quite disruptive to plans. As such, CMS should not move forward with the All Condition Count model.

In its analysis of the risk score impacts of the PCC model as compared to the 2017 model, conducted using Medicare fee-for-service (FFS) claims and enrollment data, Oliver Wyman found an overall impact of 1.1 percent, similar to what CMS found.¹ However, the results of the analyses raise a number of concerns. For example, as shown in the table below:

¹ Giese, Glenn, Sober, Josh, Fitzpatrick, Randall. 2019 Advance Notice: Changes to Medicare Advantage payment methodology and the potential effect on Medicare Advantage organizations. Oliver Wyman. February 2018.

- The PCC model *increases* risk scores for healthy individuals with no conditions and *decreases* them for people with one, two, or three diseases. The results are likely due to CMS’s decision to create a model that increases risk scores through use of dummy variables that only apply when an individual has at least four HCCs. These impacts seem inconsistent with the intent of 21st Century Cures Act to increase payments for individuals based on the count of conditions.
- The new model has troubling impacts with respect to Medicare Advantage enrollees who receive full Medicaid benefits (full duals). The risk scores for full dual aged enrollees with at least two HCCs would decrease. Full dual disabled risk scores would also decrease if they have between one and three HCCs. These impacts conflict with what CMS said it wanted to achieve when it introduced the 2017 model – to better account for the higher costs of dual eligibles.

**Change in Risk Score by HCC Count
(PCC Model vs. 2018 Risk Model)**

	All	Number of HCCs				
		0	1	2	3	4+
Overall	1.1%	3.6%	-0.2%	-2.3%	-3.5%	0.0%
Non-Dual Aged	1.3%	1.9%	-0.1%	-1.6%	-2.6%	0.5%
Non-Dual Disabled	0.6%	4.9%	0.0%	-2.3%	-3.7%	0.5%
Full-Dual Aged	0.7%	2.4%	0.9%	-1.0%	-1.9%	-1.1%
Full-Dual Disabled	0.4%	8.4%	-0.6%	-3.6%	-5.5%	0.7%
Partial-Dual Aged	0.5%	2.3%	-0.7%	-2.4%	-3.5%	-0.5%
Partial-Dual Disabled	0.6%	6.6%	-0.5%	-3.0%	-4.5%	1.0%

Source: Oliver Wyman analysis of the CMS 5 percent Standard Analytic File Limited Data Set, 2016.

We are also concerned that CMS has only presented two alternatives for stakeholders to review, and yet the agency notes that it considered **over twenty models** to account for the number of conditions of an individual. These alternatives included models that varied in terms of:

“how the conditions were counted: either a single continuous integer count variable (i.e., a coefficient C that is applied by multiplying it by the number of conditions a beneficiary has, for example, a beneficiary with 1 condition has 1 x C, a beneficiary with 2 conditions had 2 x C, etc.), individual dummy variables (individual coefficients estimated separately for 1, 2, 3, 4 conditions etc.), variables for grouped ranges of counts (a coefficient estimated for 0-3, 4-6, 7-10 conditions etc.), or a single variable for more than a specified number of conditions (a coefficient estimated for 5+, 10+, etc.).”

Moreover, of the two options presented in the Advance Notice, the All Condition Count model would be so disruptive given its variability in risk scores across plans that we believe it is not a realistic option. To allow for a full, constructive, and transparent assessment of the best approach for taking the number of conditions into account as required under the 21st Century Cures Act, we urge CMS to share with stakeholders the other alternative approaches CMS considered and their impacts. CMS should also describe why the agency believes the PCC is a better approach than any of these alternatives.

Implementation Date (2019-2022)

The 21st Century Cures Act creates a new Section 1853(a)(1)(I)(ii) that states:

“PHASED-IN IMPLEMENTATION.—The Secretary shall phase-in any changes to risk adjustment payment amounts under subparagraph (C)(i) under this subparagraph over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.”

CMS proposes to begin implementation of the new model in 2019. However, CMS notes that this language could be interpreted to allow CMS to begin implementation of the new model in either 2019 or 2020. Under this interpretation, CMS could use the 2019 Advance Notice and comment process to obtain feedback that would inform its decision for the phase-in of the new model starting in 2020. AHIP agrees with CMS’s interpretation of the statute with respect to the implementation date.

As noted above, AHIP has significant concerns with the PCC model proposed by CMS. We believe that this model, as developed, could result in unintended consequences, as the agency has now created an arbitrary threshold at four HCCs, will increase payments for individuals with no diseases, and will reduce risk scores for full dual eligibles. AHIP recommends that CMS not implement the PCC model as designed for 2019.

However, AHIP supports the inclusion of new HCCs for mental health, substance use, and chronic kidney disease stage 3. We therefore recommend that CMS move forward in beginning implementation of the model for 2019 with the additional proposed HCCs. CMS refers to this model in the Advance Notice as the “CMS-HCC without count variables” model. We believe that phasing in a risk model with the new proposed HCCs beginning in 2019 and phasing in a new condition count variable beginning in 2020, both with full implementation by 2022, is consistent with the statute.

Before proposing an additional change to the model beginning in 2020 that includes variables that account for the number of conditions of an individual, we recommend that the agency consider establishing a Technical Expert Panel (TEP), similar to the one CMS indicates is being created for Star Ratings. This TEP would be an excellent approach for ensuring development of a

model that appropriately adjusts payment for high acuity patients while not causing unintended or counterintuitive impacts on payment. AHIP and its members would welcome the opportunity to participate on such a TEP.

Model Blend

CMS notes that it will calculate the risk score using a blend of the PCC model risk score and the 2017 CMS-HCC model risk score. The PCC model risk score would be based on diagnoses from the encounter data system (EDS), supplemented with inpatient diagnoses from the Risk Adjustment Processing System (RAPS).

As we note elsewhere in our comments, we have significant concerns about the increased use of encounter data for payment. AHIP would also note that the blend proposed by CMS is not a 'true' blend and is inconsistent with how CMS has previously transitioned to a new risk model via a blend approach. As shown below, the blend CMS proposes does not account for cases in which the RAPS risk score under the new model is higher than the EDS risk score. The blend only is a true 25/75 blend if the differences between RAPS and EDS are equivalent in the 2017 risk model and the 2019 PCC model.

The equations below show how the blends are not equivalent unless this condition holds.

Let R_N = Risk Score for 2019 model using RAPS data.

Let R_O = Risk score for 2017 model using RAPS data.

Let E_N = Risk Score for 2019 model using EDS data

Let E_O = Risk Score for 2017 model using EDS data

Let S_1 = Risk Score using $\frac{3}{4}$ blend of 2017 model and $\frac{1}{4}$ blend of 2019 model for both RAPS and EDS.

$$S_1 = \frac{3}{4} \left(\frac{1}{4} R_N + \frac{3}{4} R_O \right) + \frac{1}{4} \left(\frac{1}{4} E_N + \frac{3}{4} E_O \right)$$

Let S_2 = Risk Score using $\frac{1}{4}$ 2019 model with EDS and $\frac{3}{4}$ blend of 2017 model for EDS.

$$S_2 = \left(\frac{3}{4} R_O \right) + \left(\frac{1}{4} E_N \right)$$

In its proposal, CMS assumes that the blend of the two models is equivalent for the purpose of accurately calculating risk scores. However, that is only the case if the differences between the RAPS and EDS risk scores under both the 2017 and 2019 models are equivalent.

$$\text{if } S_1 = S_2 \text{ then } S_1 - S_2 = 0$$

$$S_1 - S_2 = \frac{3}{4} \left(\frac{1}{4} R_N + \frac{3}{4} R_O \right) + \frac{1}{4} \left(\frac{1}{4} E_N + \frac{3}{4} E_O \right) - \left(\frac{3}{4} R_O \right)$$

$$S_1 - S_2 = \frac{3}{16} R_N + \frac{9}{16} R_O - \frac{1}{16} E_N + \frac{3}{16} E_O - \frac{3}{4} R_O - \frac{1}{4} E_N = 0$$

$$S_1 - S_2 = \frac{3}{16} R_N + \frac{3}{16} E_O + \frac{9}{16} R_O - \frac{12}{16} R_O + \frac{1}{16} E_N - \frac{4}{16} E_N = 0$$

$$S_1 - S_2 = \frac{3}{16} R_N + \frac{3}{16} E_O - \frac{3}{16} R_O - \frac{3}{16} E_N = 0$$

$$S_1 - S_2 = \left(\frac{3}{16} R_N - \frac{3}{16} E_N \right) = \left(\frac{3}{16} R_O - \frac{3}{16} E_O \right) \longrightarrow (R_N - E_N) = (R_O - E_O)$$

$$S_1 = S_2 \text{ iff } (R_N - E_N) = (R_O - E_O)$$

To the extent there is a difference between risk scores calculated using RAPS and EDS in the 2017 and 2019 models, CMS should take this difference into account; otherwise, the approach CMS proposes will not lead to the calculation of accurate risk scores as envisioned under the statute. We therefore believe that CMS should provide a justification for why the agency is proposing to implement the model blend under this approach, and to show the impact of implementing this approach in comparison to other approaches. Without this information, we are unable to provide full, constructive comments on this aspect of the proposed risk model changes.

If CMS does intend to implement the new model in 2019, AHIP recommends that CMS adopt a methodology that includes a blend of the RAPS and EDS data within each model, before blending the risk score. As noted by the equations above, this approach would ensure that the RAPS and EDS data are properly accounted for in each model.

Other Provisions in CY 2019 Advance Notice

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2019

End Stage Renal Disease (ESRD) Dialysis Growth Rate (p. 7). CMS notes that the expected growth rate for dialysis only ESRD is 5.07 percent. As of January 1, 2018, the drug Sensipar, which is used for treatment of ESRD, became covered under Part B and not under Part D. We

would like CMS to confirm that Sensipar expenditures are included in the estimate of the ESRD dialysis growth rate of 5.07 percent.

Attachment II. Changes in the Part C Payment Methodology for CY 2019

Section A. Medicare Advantage Benchmark, Quality Bonus Payments, and Rebate Cap on Benchmarks (pp. 13-14). We continue to believe that the pre-Affordable Care Act (ACA) cap on county benchmarks does not align with CMS's goal to reward the delivery of high quality care across the Medicare program. We therefore encourage CMS to continue to explore ways it can exercise its regulatory authority to exclude quality bonus payments from the application of the pre-ACA benchmark cap, which arbitrarily reduces payment rates for high-performing Medicare Advantage plans and has downstream impacts on the benefits available to their enrollees.

Section B. Calculation of Fee for Service Cost

Puerto Rico (pp. 15-16). Medicare Advantage is critically important in Puerto Rico. The vast majority of Medicare beneficiaries in Puerto Rico are enrolled in Medicare Advantage plans (71 percent, as of February 2018). Many of these beneficiaries have low incomes and enroll in plans to receive more care coordination and affordable Part D coverage, which otherwise may not be affordable due to the statutory prohibition on providing Part D low-income subsidies (LIS) to beneficiaries in the territories.

We continue to be concerned about the large disparity in payment rates between Puerto Rico and the mainland. The unusually low FFS expenditures for Puerto Rico, which now serve as the basis for Medicare Advantage benchmarks, and the significant rate cuts for Puerto Rico put into place by the ACA, jeopardize the continued availability of the comprehensive coverage provided by Medicare Advantage plans operating on the Island to the low-income populations they serve. Given the unique circumstances of plans in Puerto Rico, we believe that CMS should explore all potential options for increasing Medicare Advantage benchmark rates for Puerto Rico to achieve greater parity with FFS rates on the mainland. Such an adjustment is needed to ensure that plans in Puerto Rico can maintain benefits for the low-income populations they serve.

At a minimum, as CMS noted in the 2017 Final Rate Notice, the agency identified 14.3 percent of Puerto Rico beneficiaries enrolled in both Medicare Parts A and B had no claims, as compared to 6.1 percent of beneficiaries nationwide. As a result, the Secretary directed the Office of the Actuary (OACT) to account for the fact that a higher proportion of beneficiaries in Puerto Rico did not have claims than beneficiaries outside of Puerto Rico. OACT applied this adjustment in the 2018 rates, and OACT is considering whether to make this adjustment for the 2019 rates.

We believe that the adjustment for zero claims remains necessary to ensure beneficiaries maintain access to the Medicare Advantage benefits they need, given the unique characteristics

of Puerto Rico. We strongly encourage the agency to continue making this adjustment, if CMS does not apply the proxy rate policy that we have suggested above.

CMS also notes that it continues to adjust the FFS calculation for Puerto Rico to include only those beneficiaries enrolled in both Parts A and B. AHIP supports CMS continuing to make this adjustment.

In addition, in the CY2018 Final Notice CMS expanded the criteria used to determine which counties qualify for a double quality bonus payment to include certain counties in Puerto Rico. We support CMS in continuing to include these counties in Puerto Rico when determining which counties qualify for the double bonus payment in CY2019.

Average Geographic Adjustment (AGA) Methodology for 2019 (pp. 15-19). CMS proposes several changes to the calculation of the AGAs used to determine the county benchmarks. These changes are primarily associated with the shared savings and losses of ACOs. While AHIP supports the need for accuracy in the payment rates, we are concerned that we cannot assess the impacts of the changes being proposed.

In addition, with more and more enrollment in alternative payment models (APMs), the methodologies used by CMS to account for APMs in the Medicare Advantage rates could adversely affect payments to Medicare Advantage plans if not done properly. Although 2019 will be the first year in which providers participating in Advanced Alternative Payment Models (APMs) can receive a 5 percent bonus payment, CMS does not mention in the Advance Notice how the agency will account for these bonus payments in the 2019 county benchmarks or how payments from the Merit Incentive Payment System (MIPS) would impact the 2019 county benchmarks.

We strongly encourage the agency to publish estimated AGAs by county in December, when CMS publishes the preliminary growth rate for Medicare Advantage and FFS. CMS should also publish estimates of the various adjustment factors that are used to calculate the AGA. Stakeholders cannot reliably comment on changes proposed by CMS without more information on the payment impact of these changes. For the 2020 rates, CMS will likely use data from 2013 to 2017. Because these data are largely complete by July of 2018, CMS will have sufficient time to use these data in estimating the AGAs for 2020 by the fall of 2018. Increased transparency and information would be helpful to stakeholders in understanding the implications of rebasing the benchmark rates and incorporating any proposed changes by CMS.

We would also like to call attention to an inconsistency in CMS's methodology for standardizing the county benchmarks. On page 19, CMS notes that it will standardize the county benchmarks using 'the county's average five-year risk score from the 2019 risk model'. Using only the 2019 risk model to standardize the rates is inconsistent with how CMS has proposed phasing in the new model. In addition, as noted elsewhere in the Advance Notice, CMS is considering whether

to phase in the model beginning in 2020, and not 2019. The standardization of the benchmarks must be conducted using the same blend of the risk model scores that CMS is using for payment. If CMS does decide to implement the new model in 2019, then CMS should standardize the rates using a risk score with a 25/75 blend of the new model and the 2017 model. If CMS does not implement the new model, only the risk scores from the 2017 model would be used for the standardization. We would ask CMS to clarify how it intends to standardize the benchmarks in the Final Notice.

In addition, as noted above, Sensipar used for treatment of ESRD became covered under Part B and not under Part D as of January 1, 2018. It is not clear whether CMS has incorporated Sensipar expenditures into the AGAs that it uses for the ESRD benchmarks, and we ask that CMS clarify this point in the Final Notice.

Calculating FFS Costs Using Enrollees Enrolled in Medicare Part A and Part B

In the 2018 Final Rate Notice (pp 26-27), CMS noted the following:

“A large number of commenters requested that CMS calculate FFS spending based on beneficiaries enrolled in both Part A and Part B (rather than based on beneficiaries in either Part A or Part B). Commenters pointed out that in order to enroll in an MA plan, beneficiaries are required to be enrolled in both Part A and Part B. Commenters noted that beneficiaries enrolled in Part A-only had lower Part A spending than beneficiaries enrolled in both Part A and Part B. Commenters cited a recent MedPAC recommendation that benchmarks be calculated based on FFS data for beneficiaries with both Part A and Part B. Commenters requested that CMS apply a uniform approach in all counties to calculate benchmarks on beneficiaries with both Part A and Part B coverage, as is currently done in Puerto Rico. Commenters noted that other counties beyond Puerto Rico, such as in Hawaii, have high MA penetration rates and low FFS Part B enrollment. A few commenters also expressed support that the benchmarks in Puerto Rico be based on beneficiaries with both Part A and Part B coverage.”

CMS responded with the following:

“Response: We appreciate the feedback submitted by commenters regarding this issue. We will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years. While most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt-in to Part B coverage. As a result, we believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Part A and Part B.”

AHIP continues to believe that the adjustment recommended by the Medicare Payment Advisory Commission (MedPAC) is appropriate in all geographies, and not just in Puerto Rico, given the requirement that Medicare Advantage enrollees have both Medicare Parts A and B and the fact that Part A only enrollees have different health and utilization patterns.² That is, to ensure an accurate determination of FFS costs, expenditures for beneficiaries enrolled only in Part A should not be included in the calculation of the FFS benchmarks.³

Moreover, this issue is becoming more important. A growing number of beneficiaries are enrolled in Part A only, growing nationally to 12.4 percent of all FFS beneficiaries in 2015 from 10.2 percent in 2009. MedPAC expects this rate to continue growing with the popularity of MA as an option for seniors because “as more beneficiaries enroll in MA, those beneficiaries remaining in FFS are less likely to have enrolled in both Part A and Part B.” This growth in Part A only beneficiaries as a portion of all FFS beneficiaries is attributed to several reasons. Some beneficiaries are automatically enrolled in Part A and use it only as a secondary payer to employer provided health insurance they may receive as active workers. Other beneficiaries feel that they would use Part B services so infrequently as to not justify the Part B premium costs, while others determine that they simply cannot afford the Part B premium.

In addition to the policy rationale for changing such a calculation given the different cost profile and increasing numbers of Part A only Medicare beneficiaries, we have attached a legal analysis by Epstein Becker & Green, P.C., which demonstrates that under a plain reading of the Social Security Act, CMS should calculate benchmarks using claims experience only for individuals with Medicare Parts A and B. Accordingly, we urge CMS to calculate the 2019 benchmarks in the Final Notice by excluding individuals with Part A-only coverage from the calculation. Please see the legal analysis for more details.

Section G. Medicare Advantage Employer Group Waiver Plans (EGWPs)

Payment Methodology for EGWPs (pp. 25-30). CMS is proposing to fully phase-in a new payment methodology that was introduced in 2017. Under this approach, EGWP payments for 2019 would be solely based on non-EGWP bid-to-benchmark ratios. However, EGWP payments for 2017 and 2018 have been calculated using a blend of EGWP and non-EGWP bid-to-benchmark ratios, and CMS indicates it is considering maintaining this same 50/50 blend for 2019. In addition, CMS is seeking comment on making an adjustment to account for the fact that

² MedPAC found that “Part A spending for beneficiaries enrolled in Part A and Part B all year averaged 8 percent more than average Part A spending for beneficiaries enrolled in Part A (with or without Part B).” MedPAC also found that average risk scores are higher for beneficiaries enrolled in both Parts A and B compared to all FFS beneficiaries.

³ Additional independent analysis has shown that excluding Medicare beneficiaries with Part A only from the calculation of FFS costs would increase per capita FFS cost by 5 percent nationally, ranging from 3 percent to 10 percent among states. See Ashby, Jack, Young, Paul Y. Problems with CMS’s per capita cost measure push down Medicare Advantage rates and create geographic inequities. *Health Affairs Blog*. 25 January 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20180119.528795/full/>

EGWP enrollees tend to be disproportionately in Preferred Provider Organizations (PPOs) and not Health Maintenance Organizations (HMOs).

AHIP continues to oppose the EGWP payment policy implemented for 2017. Due to this policy, EGWPs may need to reduce benefits and/or increase premiums to their members. However, if CMS does not reconsider this new approach, we support the continued use of a 50/50 blend and appreciate the willingness of the agency to consider that approach.

In addition, we strongly recommend that CMS make an adjustment based on the share of EGWP enrollees in local PPOs. CMS describes this methodology on pp. 29-30 of the Advance Notice. Most EGWP members are enrolled in PPOs, but CMS's existing methodology uses ratios based primarily on HMO bids. In fact, as of February 2018, 73 percent of EGWP enrollees were in local PPOs, whereas only 17 percent of non-EGWP enrollees were in local PPOs.

Retirees who receive coverage in EGWPs are more likely to be geographically dispersed and value out-of-network options, which explains why EGWPs are more likely to be PPOs. These PPOs tend to bid differently than HMOs due to the different network options of the plans. Data included in the annual Reports to Congress submitted by MedPAC show consistently that HMOs on average bid significantly lower than PPOs. Basing EGWP payment on this different plan mix is not representative of the products in which EGWP beneficiaries are enrolled. As such, bid-to-benchmark ratios should be determined by applying an adjustment that primarily reflects bid experience from local PPOs.

Section H. CMS-HCC Risk Adjustment Model for CY 2019 (p. 30)

Please see our earlier comments on the new risk model.

Section I. ESRD Risk Adjustment Model for CY 2019 (pp. 30-34)

CMS has proposed recalibrating the ESRD model using 2014 diagnoses to predict 2015 claims. CMS notes that the current model was implemented in 2012 but used 2006 diagnoses to predict 2007 costs. As a result, there is an eight-year difference between the data used for the existing ESRD model and the new proposed recalibrated model. CMS does not indicate what accounts for this eight-year delay.

Because CMS has not recalibrated the ESRD model in several years, the proposed recalibration creates large swings in the model coefficients that may have unintended consequences for plans and their enrollees. On average, we understand the recalibration would reduce ESRD risk scores. AHIP recommends that CMS phase-in the new model over at least a two-year period in order to mitigate such impacts. CMS has applied similar phase-in approaches with the CMS-HCC model.

In addition, we again note that as of January 1, 2018, Sensipar used for treatment of ESRD is now covered under Part B and not under Part D. It is not clear whether CMS has incorporated

Sensipar expenditures into the newly recalibrated ESRD model, and we ask that CMS address this issue in the Final Notice.

Finally, we note that CMS indicates the 21st Century Cures Act requires the agency to complete an initial evaluation of the ESRD model by December 31, 2018. We request that CMS provide additional information in the Final Notice with respect to the process and timeline for conducting this evaluation, including opportunities for stakeholder engagement.

Section K. Medicare Advantage Coding Pattern Adjustment

Coding Adjustment (p. 35). The Advance Notice announces that for CY 2019, CMS is proposing to apply the statutory minimum Medicare Advantage coding adjustment factor of 5.90 percent. AHIP supports the agency's decision to maintain and not exceed the statutory minimum adjustment level.

In addition, CMS is soliciting comments on alternative methodologies that the agency is considering with regard to its final decision. CMS references these methodologies as follows:

- *"The methodology discussed in the Payment Year 2010 Advance Notice and Rate Announcement, found here: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>*
- *The methodology discussed in the Payment Year 2016 Advance Notice and Rate Announcement, also found at the same Web page.*
- *The methodology discussed in MedPAC's March 2017 Report to Congress: Medicare Payment Policy. The report can be found here: http://medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf?sfvrsn=0"*

Given the lack of details, analysis, and any other information provided by CMS, we cannot fully evaluate or meaningfully comment on these alternative methodologies. Adopting any of these alternative methodologies for 2019 would, in our view, be inconsistent with the requirements in section 1853(b) of the Social Security Act that CMS provide notice of proposed changes in methodology; provide an opportunity to comment; and include an explanation of proposed changes in methodology. For this reason, CMS should not consider any changes to the adjustment level based on these methodologies and should implement the statutory minimum 5.90 percent adjustment level for 2019 as proposed.

To the extent any future changes are considered, CMS should develop and implement a robust, transparent process – including meaningful stakeholder engagement – to evaluate both the methodology for making this calculation as well as interpreting the appropriateness and implications of any results using the most current, relevant information. While CMS should not proceed with any of the options described above, we have additional, specific concerns with two of the methodologies as described in further detail below.

The methodology discussed in the Payment Year 2016 Advance Notice and Rate Announcement. As proposed, this methodology (the “2016 Advance Notice methodology”) would effectively cap payments to Medicare Advantage plans at the payment amount that would have been calculated using the adjusted average per capita cost (AAPCC) methodology in effect prior to 2000, which only included demographic risk adjustment factors. However, section 1853(a)(3)(C) requires a risk adjustment methodology that “accounts for variations in per capita costs based on health status...”

We believe the 2016 Advance Notice methodology would be inconsistent with this statutory provision because – as a practical matter – it would remove the adjustment for health status specified in the statute. In addition, the 2016 Advance Notice methodology is clearly inconsistent with the new statutory risk adjustment requirements imposed under the 21st Century Cures Act, which mandates that the Secretary take into account the total number of diseases or conditions of an individual, as well as a separate adjustment for full dual eligible individuals.

We also note that numerous peer-reviewed, academic evaluations have determined that incorporating clinical conditions into the Medicare Advantage risk adjustment model has been highly successful in better aligning enrollment of high risk beneficiaries with expected health care spending.^{4,5} Eliminating the use of clinical information in determining risk scores would dramatically underestimate costs for individuals with multiple chronic conditions by ignoring any use of diagnoses, and would reverse substantial progress made in Medicare Advantage risk adjustment.

The methodology discussed in MedPAC’s March 2017 Report to Congress: Medicare Payment Policy. The methodology discussed by MedPAC (the “2017 MedPAC methodology”) has three distinct components: 1) develop a risk adjustment model that uses two years of FFS and Medicare Advantage diagnostic data, 2) exclude diagnoses that are only documented on health risk assessments from either FFS or MA, and 3) apply a coding adjustment that fully and equitably accounts for the remaining differences in coding between FFS Medicare and Medicare Advantage plans.

It is unclear whether CMS’s reference to the 2017 MedPAC methodology was intended to incorporate all three components. However, if the first component is under consideration, we note that Congress explicitly provided the Secretary with the authority to calibrate the risk adjustment model using two years of data in the 21st Century Cures Act. We support CMS’s decision to not propose this approach and instead to continue calibrating the risk adjustment model with one year of data.

⁴ McWilliams, J. Michael, Hsu, John, Newhouse, Joseph P. New risk-adjustment system was associated with reduced favorable selection in Medicare Advantage. *Health Affairs* 31(12):2630-2640. December 2012.

⁵ Newhouse, Joseph P., McGuire, Thomas G. How successful is Medicare Advantage? *Milbank Quarterly* 92(2): 351-394. June 2014.

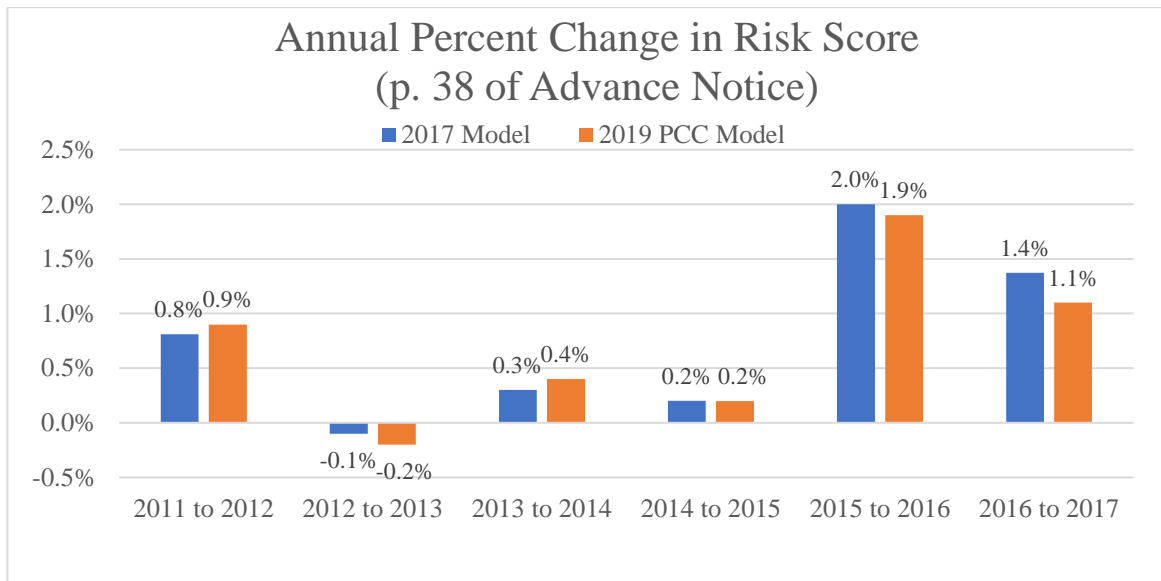
With respect to the second component, when CMS indicated in prior Advance Notices that it would consider limits relating to clinical encounters documented in health risk assessments (HRAs), AHIP opposed such approaches. We would be similarly opposed to any such limits in the future. HRAs are an important component of disease management activities to promote early identification of chronic conditions and focus on prevention, wellness, and care coordination. To exclude these diagnoses from the risk adjustment model would eliminate an essential element of problem identification, medication management, and continuity of care. A recent *Health Affairs* article found Medicare Advantage plans reduced inpatient hospitalizations by up to 14 percent compared to FFS by conducting in-home HRAs and implementing treatment programs for conditions identified during these visits.⁶

With respect to the third component, neither MedPAC nor CMS has described in sufficient detail how a coding adjustment that “fully and equitably accounts” for differences in Medicare Advantage and FFS coding patterns would be calculated or applied to Medicare Advantage plans. No potential changes of this sort should be considered absent a detailed methodology for how the adjustment would be calculated and applied, and analyses of the impacts on enrollee premiums and benefits, made publicly available with substantial time for review and comment.

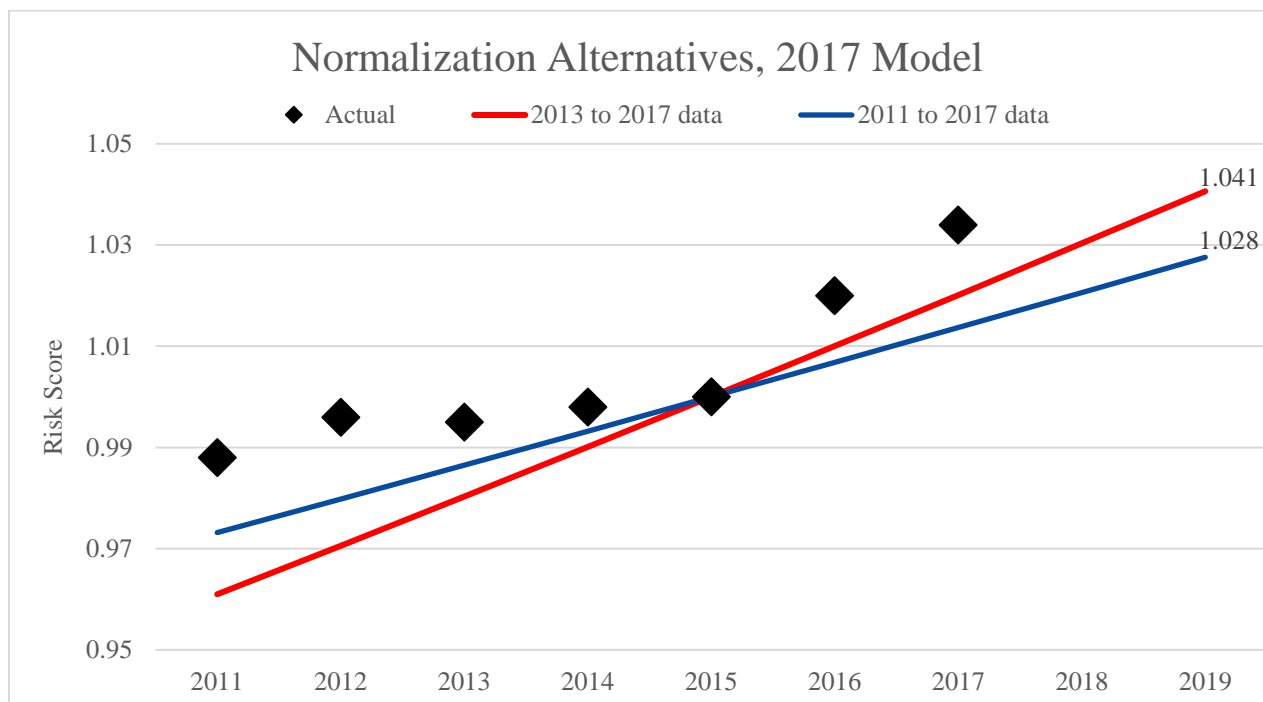
Section L. Normalization Factors

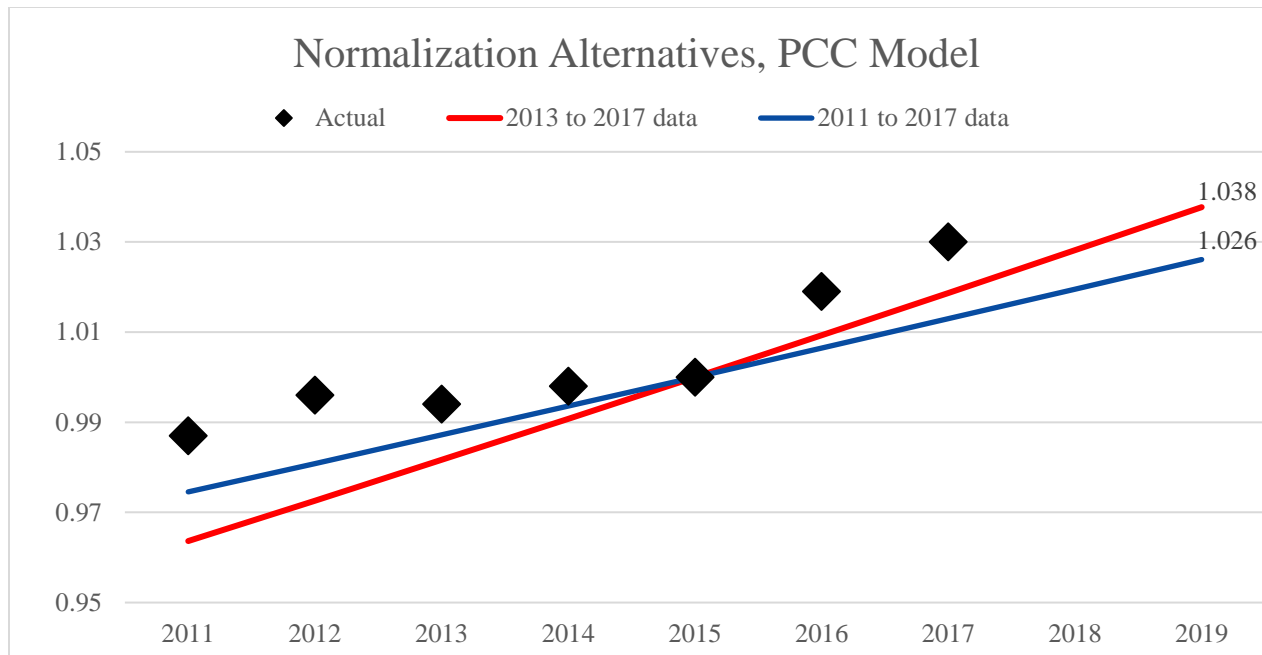
CMS-HCC Model Normalization Factor (pp. 36-38). CMS proposes a normalization factor of 1.041 for the 2017 CMS-HCC model, and 1.038 for the proposed PCC model, which would result in a 2.3 percent payment reduction to Medicare Advantage plan payments from 2018. CMS proposes to use risk score data from 2013 to 2017 to estimate the normalization factor. We are concerned with the proposed data years. CMS notes large increases in the average FFS risk score for both 2016 and 2017. The 2016 and 2017 risk scores appear to be outliers, as compared to data from 2011 to 2015, for both the 2017 model and the PCC model, as shown in the graph below.

⁶ Mattke, Soeren, Han, Dan, Wilks, Asa et al. Medicare home visit program associated with fewer hospital and nursing home admissions, increased office visits. *Health Affairs* 34(12): 2138-2146. December 2015.



Furthermore, as shown in the graphs below, the blue line – which is a linear function that fits the 2011 to 2017 data – appears to be a more accurate representation of the values for 2011 to 2017 than the red line, which is a linear function that fits the 2013 to 2017 data, as CMS has proposed. Were CMS to use the 2011 to 2017 data points to estimate the trend, the normalization factor for 2019 for the 2017 model and the PCC model would be 1.028 and 1.026 respectively, rather than the 1.041 and 1.038 figures estimated by CMS using the 2013 to 2017 data.





We believe an explanation for the large increases in the 2016 and 2017 risk scores may be the introduction of ICD-10 codes that occurred on October 1, 2015. That is, diagnoses recorded during the first nine months of 2015 were documented using ICD-9 codes, while diagnoses recorded during the final three months of 2015 were documented using ICD-10 codes. The ICD-10 code set is much larger than the ICD-9 code set. If the ICD-10 switchover accounts for this increase, it would suggest that the normalization factors calculated by CMS are more of an artifact of the difference between ICD-10 and ICD-9 mapping to the HCCs, and coding differences in ICD-10 vs. ICD-9, than a real indication of higher risk scores in FFS Medicare. In addition, both the 2017 model and the PCC model are estimated on ICD-9 data, yet the 2016 and 2017 risk scores use ICD-10 data. This discrepancy between model estimation and model payment could be a likely cause of this increase, as compared to increases in risk scores due to changes in coding practices.

To explore whether the transition to ICD-10 codes could account for the increase in the risk scores, Oliver Wyman conducted analyses to look at the number of HCCs using diagnoses from all of 2015 vs diagnoses from only the first nine months of 2015 and compared that to the number of HCCs using diagnoses from all of 2014 diagnoses versus diagnoses from only the first nine months of 2014. Oliver Wyman found a notable difference in the composition of the HCCs, particularly with respect to diabetes. As shown in the table below, the prevalence of HCC18, Diabetes with Complication, was 12.1 percent for the 2015 cohort, but only 9.9 percent for the 2014 cohort. Conversely, the prevalence of HCC19, Diabetes without Complication, was 12.8 percent for the 2015 cohort but 15.1 percent for the 2014 cohort.

Using only diagnoses from the October to December time period shows differences in prevalence that are not present when looking at diagnoses from the January to September time period. That is, the introduction of the ICD-10 codes appears to make it more likely that a person with diabetes will be coded as having diabetes with chronic complications. Because HCC18 carries a higher coefficient value than HCC19, the switch from HCC18 to HCC19 appears to account for the increase in risk score.⁷

HCC	HCC Label	2014 Cohort - % of Pop with HCC (2014 diagnoses)			2015 Cohort - % of Pop with HCC (2015 diagnoses)		
		Jan-Sept	Oct-Dec	CY	Jan-Sept	Oct-Dec	CY
HCC18	Diabetes with Chronic Complications	8.8%	5.7%	9.9%	9.2%	8.6%	12.1%
HCC19	Diabetes without Complication	14.8%	12.0%	15.1%	14.5%	9.0%	12.8%

Source: Oliver Wyman analysis of the CMS 5 percent Standard Analytic File Limited Data Set, 2013-2015.

AHIP strongly recommends that CMS use 2011 to 2017 data to determine the normalization factor, given that: 1) 2016 and 2017 data are outliers, 2) the risk score increases appear to be stemming from the use of ICD-10 codes, and 3) as a general principle, CMS should use more data points in order to have more stable estimates of normalization. Using the 2013 to 2017 data points runs the risk of over normalizing for 2019 by setting the normalization factor too high. We are concerned that CMS is placing too much weight on the ICD-10 codes by not using the 2011 and 2012 data points to estimate the normalization trend.

Normalization Factor for the Functioning Graft and PACE models (pp. 38-39). The PACE and functioning graft models have the same normalization factor of 1.159. This estimate is derived by using the 2013 to 2017 data points, which have the same problems as noted above. AHIP recommends that CMS use 2011 to 2017 data points for the functioning graft and PACE model normalization factors. We would also note that CMS should re-estimate the PACE model more frequently so that it is not estimating a normalization trend that attempts to project 10 years of trend.

CMS states that it is seeking feedback on “whether to apply a different approach to determining the normalization factor for the model used for the PACE program.” We would note that CMS should be seeking this same feedback on all of its models, not only for the PACE model. Furthermore, the large normalization factor is a function of CMS’s decision not to recalibrate the

⁷ Oliver Wyman used the 5 percent standard analytic Medicare claim files and the 100 percent enrollment data base files to conduct their analysis. They developed cohorts for July 2015 enrollees, and for July 2014 enrollees, and calculated risk scores for 2014 and 2015 (for the July 2014 cohort, using 2013 and 2014 diagnoses) and 2015 and 2016 (for the July 2015 cohort, using 2014 and 2015 diagnoses). By keeping the cohort fixed, they were able to isolate the change in risk scores associated with HCCs while also looking at the composition of HCCs.

PACE model. As we have discussed in our comments on the ESRD model, waiting long periods of time between model recalibrations creates wide swings in the model coefficients.

Normalization Factor for the ESRD Dialysis Model and Post Graft Model (pp. 39-40). CMS proposes a normalization factor of 1.033 for the dialysis model and 1.048 for the post-graft model. These normalization factors are estimated based on using 2013 to 2017 data. As discussed above, we believe that CMS should estimate the normalization factors for both of these models using 2011 to 2017 data.

Section N. Encounter Data as a Diagnosis Source for 2019 (pp.42-43)

For 2019, CMS is proposing to increase the percentage of risk scores based on diagnoses submitted through EDS to 25 percent, up from 15 percent in 2018. CMS is also proposing to supplement encounter data-based risk scores with inpatient diagnoses submitted to RAPS. In addition, as described above, CMS is further proposing to use only encounter data in the 2019 PCC risk model, which would be phased in over the four-year period 2019 to 2022 by increasing the percent of the new risk model by 25 percentage points each year. By solely using encounter data in the new risk model, CMS would therefore also be fully phasing in the use of encounter data for risk adjustment by 2022 under this proposal.

AHIP members are fully committed to the submission of complete and accurate Medicare Advantage encounter data to CMS, and have worked diligently since 2012 to develop, implement, manage, and monitor the operations necessary to achieve this goal. Our members have invested significant resources to collect and submit these data and appreciate the need for CMS to capture information about Medicare Advantage treatment and cost patterns. We also recognize that, over the past year, CMS has increased its efforts to obtain input from individual Medicare Advantage plans about technical and operational issues with EDS, such as through listening sessions, and to provide more technical assistance via one-on-one communications, webinars, and Health Plan Management System (HPMS) memoranda.

While we appreciate these efforts, we believe that significant problems and uncertainties with EDS persist. We also have serious concerns with the fact that the transition to encounter data will result in a payment reduction to the program, as estimated by CMS and in the Administration's 2019 budget proposal. These issues require that CMS pause the transition to encounter data as the source of diagnoses used for risk adjustment – and not follow any arbitrary schedule that achieves a full phase-in – until (1) all of the operational problems have been demonstrably resolved, (2) the recommendations made by the Government Accountability Office (GAO) in July 2014 and January 2017 have been fully addressed, and (3) the transition to encounter data is determined to be budget neutral. We also reiterate the recommendation made to CMS in our response to the April 2017 Request for Information that the agency improve the process through which payment and operational issues are approached through regular, transparent, and structured collaboration with the industry.

Significant Discrepancies between RAPS and EDS. Numerous independent studies have documented a discrepancy in Medicare Advantage plan risk scores calculated using RAPS in comparison to EDS. A study published by Avalere in October 2017, updating a prior study published in February 2017, estimated that on average – using a sample of six Medicare Advantage organizations representing 760,000 enrollees – Payment Year (PY) 2016 risk scores calculated using EDS are 3 percent lower than using RAPS.⁸ A recent report by the actuarial firm Milliman also estimated a significant difference in risk scores calculated using RAPS and EDS.⁹ In its study published in February 2018, Milliman found a median difference of 3.1 percent between PY2016 RAPS and EDS risk scores using a sample of 10 Medicare Advantage organizations representing over 300,000 enrollees. Milliman found that this difference continued into PY2017, with a median difference in risk scores of 2.5 percent. Moreover, Special Needs Plans, which care for some of the most complex and vulnerable beneficiaries in the Medicare program, had a median difference in PY2017 of 5.2 percent – more than twice as much as Medicare Advantage plans overall.

Reductions in Payment Resulting from Transition to EDS. It has been the stated intention of CMS since encounter data was first included as a primary source of diagnosis data in the 2016 Final Notice that risk scores calculated using RAPS and EDS would be equivalent. In the 2016 Final Notice, CMS stated that, “since the same diagnoses that are submitted into RAPS can be submitted into the encounter data system, we anticipate that the scores should be similar.” In addition, CMS indicated that as, “the encounter data system does not change the definition of acceptable diagnoses or limit their submission, CMS anticipates that the risk scores calculated using encounter data will reflect the same coding trend as those calculated with RAPS-based diagnoses.”

However, through its own impact analysis of the policies proposed in the 2019 Advance Notice, CMS clearly acknowledges – for the first time – that the transition to encounter data as a source of diagnoses for risk adjustment results in a payment reduction for the Medicare Advantage program. CMS estimates that increasing the percentage of encounter data from 15 percent in 2018 to 25 percent in 2019 will result in a 0.04 percent payment reduction. In addition, the fiscal year (FY) 2019 President’s Budget explicitly includes the encounter data transition proposal included in the 2019 Advance Notice as a budget offset. The budget proposal, labeled “Eliminate Excessive Payment in Medicare Advantage by Using Claims Data from Patient Encounters,” estimates that the proposed transition to encounter data will reduce Medicare Advantage spending by \$11.1 billion over 10 years.

⁸ Avalere. Impact evaluation: Medicare Advantage transition from RAPS to EDS. October 2017. Available at: <http://avalere.com/expertise/managed-care/insights/impact-evaluation-medicare-advantage-transition-from-raps-to-eds>

⁹ Bell, Deanna, Koenig, David, Mills, Charlie. Medicare Advantage’s transition from RAPS to EDS risk scores: 2017 impact. Milliman White Paper. February 2018. Available at: <http://us.milliman.com/uploadedFiles/insight/2018/Medicare-RAPS-to-EDS-2017.pdf>

Both the estimated negative payment impact of this policy, and its characterization by the Administration as eliminating ‘excessive payment’, conflict with prior CMS statements that risk scores calculated under RAPS should be similar to risk scores calculated under EDS. We strongly oppose the transition to encounter data as a means of reducing payments by purposefully calculating risk scores materially lower than those calculated under RAPS.

Technical and Operational Issues with Encounter Data. AHIP and our member plans also continue to have serious concerns with numerous technical and operational aspects of EDS that have prevented plans from evaluating the completeness of their encounter data submissions, fully analyzing the impact of the transition to encounter data-based risk scores, and receiving timely payment. Over the past year, our member plans have separately provided CMS with specific examples of ongoing operational and technical problems relating to the acceptance and processing of encounter data through listening sessions, submissions to various mailboxes, and questions asked on monthly user group calls. Despite these various outreach efforts, to date CMS has been unable to provide plans with complete information about the impacts of using encounter data on risk scores. This absence of information is increasingly problematic.

For example, CMS did not separately provide plans with risk score data calculated using RAPS and EDS for understanding the impacts of the proposed 2019 PCC risk model. As a result, plans were not able to isolate the impact of using encounter data from the impacts of the other substantive changes proposed in the 2019 PCC risk model. In addition, the report plans need to determine which diagnoses will be used by CMS to calculate risk scores after application of the agency’s filtering logic – called the MAO-004 report – is in its fourth iteration, and CMS has not yet released the anticipated fifth iteration. The Exhibits below summarizes the timeline of these iterations, along with CMS’s decisions regarding the use of encounter data for payment (although the multiple MAO-004 report iterations have delayed final reconciliation payments for PY2015-PY2017, for simplicity, this chart is limited to payment reconciliation for PY2016).

Timeline of CMS Issuing MAO-004 Encounter Data Return Files and Reconciling Final PY2016 Payment, 2014-2018

EDS Return Files (MAO-004s)	PY2016 Payment Reconciliation
Nov 2014: CMS announces files will be issued	May 2015: Submission deadline announced
Dec 2015: CMS issues files	Dec 2016: EDS deadline extended (date TBD)
Oct 2016: CMS re-issues files (Phase II)	Jan 2017: Original EDS submission deadline
Mar 2017: CMS re-issues files (Phase III)	Mar 2017: EDS deadline extended
May 2017: CMS re-issues files (Phase III v2)	May 2017: First extended EDS deadline
Apr 2018: CMS re-issues files (Phase III v3)	Oct 2017: Interim final payment reconciliation
	Dec 2017: EDS deadline extended (date TBD)
	Feb 2018: Final EDS deadline and payment announced
	Apr 2018: Second EDS extended deadline
	Jul 2018: Second interim final payment reconciliation
	Aug 2018: Final extended EDS deadline
	Nov 2018: Final payment reconciliation

We continue to believe that, since CMS issues the MAO-004 report on a monthly basis – in contrast to RAPS return files, which are provided on a daily basis – it is difficult for plans to identify errors in EDS and resubmit data in a timely fashion.

GAO Recommendation. As we have noted in prior comments to the agency, GAO released a report in January 2017¹⁰ that updated its July 2014¹¹ study on the steps CMS has taken to validate Medicare Advantage encounter data. At that time, GAO determined that CMS had yet to undertake activities that fully address encounter data accuracy, and that numerous stakeholders were concerned with CMS’s ability to properly identify diagnoses used for risk adjustment. GAO concluded that, “CMS should implement GAO’s July 2014 recommendation that CMS fully assess data quality before use,” including for payment purposes.

In the 2016 Final Notice, CMS indicated that the agency “will monitor the impact of using encounter data-based diagnoses on risk scores and risk score trends,” but has not publicly released any information based on these monitoring activities. CMS did not substantively address comments about the completeness, accuracy, or validity of EDS in the 2017 Final

¹⁰ Government Accountability Office. Medicare Advantage: Limited progress made to validate encounter data used to ensure proper payments [GAO-17-223]. January 2017. Available at: <http://www.gao.gov/products/GAO-17-223>

¹¹ Government Accountability Office. Medicare Advantage: CMS should fully develop plans for encounter data and assess data quality before use [GAO-14-571]. July 2014. Available at: <https://www.gao.gov/products/GAO-14-571>

Notice. In the 2018 Final Notice, CMS stated – in response to comments concerning plans to increase the use of encounter data in the future – that it “will convey additional information on a transition plan in the near future.” But CMS has yet to release information on a transition plan, measures to assess the completeness and accuracy of the encounter data for validation purposes, or enough information to allow for a robust determination of the validity of EDS. In fact, in the proposed rule for making policy and technical changes to Medicare Advantage for 2019, CMS indicated that it, “expects that MA encounter data will be more accurate and complete in the future.”

We support CMS’s proposal to use inpatient diagnoses from RAPS to supplement EDS but recommend that CMS also supplement EDS with outpatient and professional diagnoses from RAPS until risk scores from both systems are shown to be equivalent. In addition, until CMS has shown that the encounter data are complete and accurate, we believe it is inappropriate for CMS to increase the use of encounter data or contemplate a full phase-in of the encounter data for payment purposes. To address the ongoing technical and operational issues with EDS, CMS should also implement a transparent, structured process through which Medicare Advantage organizations and other stakeholders can collaborate in a meaningful way to achieve resolution.

Impact of Filtering Logic on Risk Scores. We remain concerned with the impact on risk scores of the EDS filtering logic, which is different from the logic CMS used to estimate the 2017 CMS-HCC model (i.e., RAPS filtering logic). A recent analysis by Wakely¹² found that Medicare FFS risk scores are 3 percent less using the EDS filtering logic than using the existing RAPS based filtering logic. Much of this decrease appears to be due to the impact of the filtering logic for professional claims. The difference in risk scores associated with the filtering logic seems at odds with CMS’s statement in the 2016 Final Notice that “the filtering logic will not change the rules regarding risk adjustment allowable diagnoses.”

We appreciate that CMS has, in part, recognized this discrepancy in the 2019 Advance Notice by calibrating the PCC model with the EDS filtering logic and proposing only to use encounter data for this model. However, for the payment years 2016-2018, the risk model was calibrated on RAPS filtering logic and applied to both RAPS and EDS. The EDS filtering logic predicts a lower average cost than would be predicted based on the RAPS filtering logic used to develop the 2017 model. Because of how predicted costs are incorporated into the CMS-HCC risk model denominator, risk scores to Medicare Advantage plans on average are lower than they should be if the filtering logic were applied in a consistent manner. Were CMS to have applied the EDS filtering logic consistently in model estimation and payment in 2016-2018 as suggested by actuarial principles,¹³ we believe that the encounter data-based risk scores would be 2 to 3 percent higher.

¹² Wakely Consulting Group. Impact of EDS on MA risk scores. September 2016. Available at: <http://www.wakely.com/wp-content/uploads/2016/08/Impact-of-EDS-on-MA-Risk-Scores-White-Paper.pdf>

¹³ See, e.g., [Society of Actuaries’ Actuarial Standards of Practice #45](#), which “is intended to provide guidance regarding the appropriate use of health status based risk adjustment models and methods.” Section 3 addresses how

Since CMS cannot demonstrate EDS is reliable for 2016, 2017, or 2018 payment, and applied a different filtering logic to EDS in these years than was used to develop the risk model, we believe CMS must take steps to address the likely errors in its payments. We believe an appropriate way for CMS to address this issue is to ensure any plan payments are not reduced from the use of encounter data. That is, the agency should determine how to most appropriately adjust risk scores to ensure payments are no less from the use of EDS than they would be from the use of RAPS data. Such an adjustment would be entirely consistent with CMS efforts to correct data errors through the use of retrospective payment reconciliations, as the use of encounter data was initially intended to be budget neutral and CMS regularly corrects other errors in payment data such as demographic factors. Moreover, this adjustment would not change CMS's decision to use encounter data as part of the blended payment for 2016-2018, but would recognize the need for a technical adjustment due to systemic errors with EDS.

Attachment III. Changes in the Payment Methodology for Medicare Part D for CY 2019

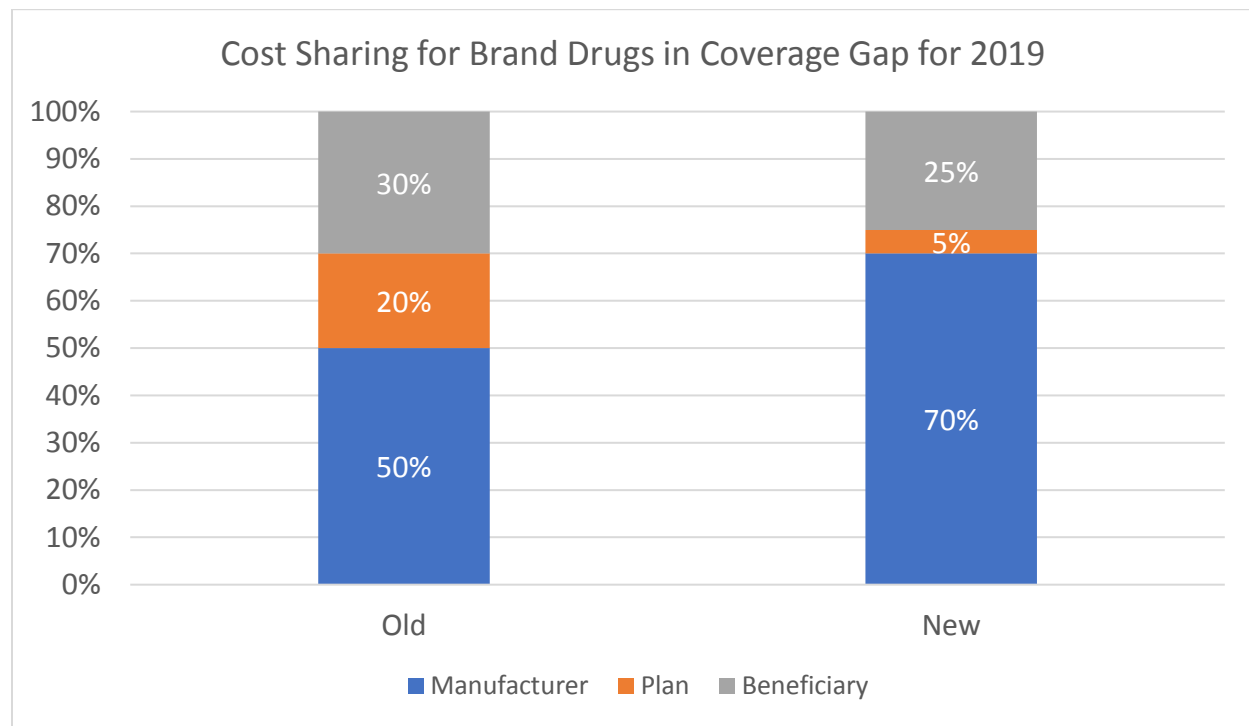
Section A. Update of the RxHCC Model (pp. 45-46)

The Bipartisan Budget Act (BBA) of 2018 increases manufacturer share and reduces plan liability for brand drugs in the coverage gap. However, the Part D risk model proposed by CMS for 2019 represents parameters that are no longer in effect for 2019. The graph below shows the differences.

Given the changes from the BBA, we believe that CMS needs to recalibrate the Part D risk model. If CMS does not recalibrate the model, then the Part D plan bids will not be properly standardized.

an actuary should consider differences between the development and the application of the risk adjustment methodology. For example, section 3.2 states:

Input Data—*The type of input data that is used in the application of risk adjustment should be reasonably consistent with the type of data used to develop the model*



Attachment IV. Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2019

Section E. Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries (pp. 63-64)

As noted in our comments on the update of the RxHCC model, the BBA of 2018 increased the amount of the manufacturer discount in the coverage gap from 50 to 70 percent for 2019, while also decreasing beneficiary cost sharing to 25 percent. However, the threshold for applicable beneficiaries calculated in the Advance Notice was based on the 50 percent manufacturer discount and 30 percent cost sharing. We anticipate that CMS will update the OOP threshold in the Final Notice and Call Letter.

Attachment VI. Draft 2019 Call Letter

Section I – Parts C and D

Annual Calendar (pp. 100-105)

CMS indicates that the annual calendar included in the draft Call Letter includes key dates and timelines for operational activities that pertain to Medicare Advantage and Part D plans.

Given the breadth and scope of proposed changes in the MA and Part D proposed rule for 2019, we recommend that CMS consider moving up relevant timelines for issuance of sub-regulatory guidance upon release of the final rule to ensure that plans have access to necessary guidance and sufficient lead time to implement changes for 2019. For example, the annual calendar indicates that the 2019 Medicare Marketing Guidelines (MMG) would be released sometime between mid to late June 2018. Many provisions in the Medicare Advantage and Part D proposed rule for 2019 impact the marketing rules such as the proposed flexibilities for benefit designs, revised definition of marketing, and rules related to the new open enrollment period. Releasing sub-regulatory guidance as expeditiously as possible would help ensure successful implementation of these new requirements.

Enhancements to the 2019 Star Ratings and Future Measurement Concepts (p. 106)

CMS announces plans to establish a Technical Expert Panel (TEP) through its contractor, RAND Corporation, in 2018 that would be comprised of representatives from stakeholder groups directed to provide recommendations on potential future Star Ratings enhancements. Focus areas would include but are not limited to the Star Ratings framework, methodology, operational measures, and data integrity reviews.

AHIP strongly supports the establishment of the TEP as a means of incorporating a more transparent and collaborative process for future Star Ratings program changes. We also believe that in order to improve Star Ratings program transparency and predictability, CMS should ensure the TEP's areas of focus will include the crucial issues of a multiyear strategic plan for adoption and retirement of Star Ratings measures, pre-determined cut points for Star Ratings measures, and ways to make the Categorical Adjustment Index (CAI) methodology more appropriate and impactful, without adversely affecting plan performance.

New Measures for 2019 Star Ratings (pp. 107-108)

Statin Use in Persons with Diabetes (Part D) and Statin Therapy for Patients with Cardiovascular Disease (Part C). CMS proposes to add the Part D Statin Use in Persons with Diabetes and the Part C Statin Therapy for Patients with Cardiovascular Disease measures to Star Ratings in 2019. Additionally, CMS proposes to categorize the Part C Statin measure as a process measure and apply a weight of 1 to this measure in 2019. CMS also proposes to apply a weight of 1 to the Part D Statin measure in 2019 but indicates that for subsequent years the Part D Statin measure would be categorized as an intermediate outcome measure with a weight of 3.

We support the inclusion of these statin measures in Star Ratings with a weight of 1 for 2019. For consistent treatment of these measures and to ensure that weighting changes occur prospectively (in advance of the measurement period), we recommend that both the Part C and Part D Statin measures continue to be weighted at 1 for 2020 Star Ratings. Further, we

recommend that any substantive changes, including changes to the weighting of the Part D Statin measure, should be considered and proposed through the future Star Ratings rulemaking process. Finally, we recommend that CMS work with the measure developers to continue to consider alternative non-statin therapies and additional exclusions due to contraindications and/or intolerance to statins.

Changes to Measures for 2019 (pp. 108-112)

Improvement measures (Parts C & D). Consistent with our comments in response to the MA and Part D proposed rule, we recommend that CMS extend the hold harmless provision to individual measures in the Improvement Measure calculation for which plans achieved and maintained at least 4 stars. The intent of the hold harmless provision is to prevent a measure from lowering a contract's improvement score when the contract still demonstrates high performance for that measure from year to year. Given the high level of performance that a 4-star rating demonstrates, we believe plans should be similarly held harmless when they achieve and maintain at least 4 stars for a measure.

Medication Adherence (ADH) for Hypertension (RAS Antagonists) and Medication Adherence for Diabetes Medications (Part D). CMS proposes to expand its data sources for identifying Part D enrollees with ESRD for exclusion from these measures. CMS proposes to use ICD-10-CM codes and RAPS RxHCCs, in addition to its current use of the Medicare Enrollment Database (EDB) ESRD indicator.

We support CMS's proposal to use additional data sources to identify and exclude beneficiaries with ESRD from these measures.

Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D). For these measures, CMS proposes to change how it calculates the Proportion of Days Covered (PDC). The PDC is adjusted for inpatient stays and hospice enrollment for MA-PDs and PDPs, and skilled nursing facility stays for PDPs. Specifically, CMS proposes to link consecutive stays to create a single admission and discharge date for the PDC adjustment.

We support CMS's proposal which would ensure appropriate days are captured in the PDC adjustment.

MPF Price Accuracy (Part D). CMS proposes to continue to include the current Medicare Plan Finder (MPF) Price Accuracy measure in Star Ratings for 2019, 2020, and 2021 using the same methodology used for the 2018 Star Ratings and intends to add a modified version of the measure to the display page for 2020 and 2021 and to Star Ratings for 2022. The proposed changes to the current MPF Price Accuracy measure are as follows: (1) revised measure would factor how much and how often prescription drug event (PDE) prices exceeded the prices

reflected on the MPF by calculating a contract's measure score as the mean of the contract's price accuracy and claim percentage scores, (2) the number of claims included in the revised measure would be increased, and (3) a drug's MPF cost would be rounded to two decimal places for comparison to its PDE cost.

We support retention of the current MPF Price Accuracy measure in Star Ratings for 2019 and subsequent years until a modified version of the measure is appropriate for inclusion in Star Ratings. Regarding the revisions that CMS proposes to make to the MPF Price Accuracy measure, we are concerned that these modifications do not account for price swings due to the volatility of the market that could impact plan performance. We also believe that the revised measure should remain on the display page to allow for comprehensive evaluation and validation and that CMS should propose the revised measure through the future rulemaking process prior to inclusion in Star Ratings, in accordance with principles set out in the proposed rule.

Removal of Measures from Star Ratings (pp. 112-113)

Beneficiary Access and Performance Problems (BAPP) (Parts C & D). CMS proposes to retire the current Part C and Part D BAPP measure for 2019 Star Ratings and include a modified version of the BAPP measure on the display page for 2019. The revised BAPP measure would only include Compliance Activity Module (CAM) data (e.g., notices of non-compliance, warning letters, ad-hoc corrective action plans (CAPs) and their severity) and would not include sanctions or civil money penalties (CMPs).

Given our longstanding concerns with the incorporation of audit findings and enforcement actions into the Star Ratings, we believe that CMS's proposals related to the BAPP measure are a step in the right direction. In addition, we believe that placing the revised BAPP measure on the display page would enable CMS and plans to assess the usefulness of the revised measure that would only include CAM data. We also recommend that the revised BAPP measure remain on the display page until it is fully evaluated and validated and the introduction of a revised version of the BAPP measure to Star Ratings should be subject to the future Star Ratings rulemaking process.

Reducing the Risk of Falling (Part C). CMS proposes to remove the current Reducing the Risk of Falling measure from 2019 Star Ratings due to changes made by the National Committee for Quality Assurance (NCQA) that would impact the measure's denominator and underlying survey questions in the Health Outcomes Survey (HOS).

We support the removal of this measure from 2019 Star Ratings given the substantive nature of the changes being made.

Data Integrity (pp. 113-114)

CMS proposes to continue its data integrity reviews to identify incomplete or biased Star Ratings measure data and intends to automatically downgrade scores to 1 star for non-appeals measures (e.g., HEDIS, HOS, CAHPS reporting, measures based on Parts C and D data reporting requirements, etc.). Additionally, CMS indicates that for the Part C SNP Care Management and Part D Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) measures, a contract would be deemed non-compliant (and subject to automatic downgrade to 1 star) if the contract either receives a “No” or a 1, 2, or 3 on the 5-point Likert scale in the specific data element’s data validation.

As we indicated in our comments in response to the Medicare Advantage and Part D proposed rule for 2019, we are very concerned with and do not support CMS’s policy to automatically downgrade rating scores to 1 star for non-appeals measures. We continue to recommend that CMS engage with AHIP, plans, and other relevant stakeholders to consider alternative approaches to the current policy for non-appeals measures such as scaled reductions for all measures and ensuring that severe penalties are not applied inappropriately (e.g., where the data submission error is identified early on, is not egregious or systemic, and is curable during the plan preview period).

Proposed Scaled Reductions for Appeals IRE Data Completeness Issues (pp. 114-122)

CMS proposes to apply scaled reductions as described in the Medicare Advantage and Part D proposed rule for 2019 to the Parts C and D appeals measures for 2019 Star Ratings. Scaled reductions would be based on the degree to which the Independent Review Entity (IRE) data are missing. CMS also indicates that the data sources for the scaled reductions would include the appeals timeliness monitoring project (TMP) or information from program audits.

We support CMS’s proposal to use scaled reductions for the appeals measures for 2019 Star Ratings. We do however caution the use of TMP data until CMS and plans are assured that the results from the TMP are accurate and reliable for use in the agency’s data integrity reviews. We also recommend that CMS ensure that during the TMP process plans have an opportunity to work with the IRE to address and resolve data discrepancies that warrant reconsideration.

2019 Star Ratings Program and the Categorical Adjustment Index (pp. 122-132)

CMS proposes to continue the use of the categorical adjustment index (CAI), which was implemented as an interim analytic adjustment to account for disparities in MA plan performance associated with socioeconomic status (SES) and includes adjustments based on low-income subsidy and dual eligible (LIS/DE) and disability status. CMS indicates that the overall methodology would remain unchanged for 2019 Star Ratings.

AHIP supports the continued use of the CAI in the Star Ratings System while CMS develops a long-term solution to this problem. However, as we indicated in our comments in response to the Medicare Advantage and Part D proposed rule for 2019, we believe that the CAI should be improved. We continue to recommend that CMS make the CAI more appropriate and impactful without adversely affecting plan performance, with the following enhancements:

- Relax the Measure Inclusion Criteria. CMS determines which measures should be included in the development of the CAI based on two restrictive criteria that compare performance between LIS/DE and non-LIS/DE beneficiaries. However, to our knowledge, CMS has not provided a methodological justification for these criteria. CMS's own analysis demonstrates there are additional measures that show meaningful differences in plan performance due to beneficiary-level social risk factors, which could be included in the development of the CAI. If CMS lowered the threshold of its second criterion from 100 percent for the proportion of LIS/DE subgroups performing better or worse than non- LIS/DE subgroups across contracts, additional measures could be incorporated into the calculation of the CAI. For example, more than 97.5 percent of contracts performed worse on their LIS/DE subgroup for Controlling Blood Pressure, 95 percent performed worse for Part D Medication Adherence for Diabetes Medications and Part D Medication Adherence for Cholesterol, and 90 percent performed worse for Diabetes Care – Eye Exam. AHIP recommends that those measures also be included, and that CMS provide a more detailed analytic justification for how its inclusion criteria are developed and applied.
- Incorporate Across-Contract Differences in Performance. The CAI methodology is currently limited to within-contract differences, meaning that the CAI values are developed based only on differences between LIS/DE and non-LIS/DE beneficiaries enrolled in the same contract. However, in its initial report, ASPE found there are real differences in plan performance between contracts serving primarily LIS/DE and disabled populations and those that do not. CMS should investigate how across-contract differences in performance can be appropriately reflected in the CAI.
- Hold Plans Harmless. As the CAI is an interim analytic adjustment, we believe that CMS should hold plans harmless from reductions in Star Ratings due to the CAI until various methodological issues – such as the criteria for measure inclusion and the incorporation of across-contract differences – are addressed, and related analytic issues being explored by ASPE, the measure developers, and other stakeholders are better understood.

Until the ASPE report is released and CMS has fully implemented a long-term solution to address SES disparities in the Star Ratings program based on its findings, we urge CMS not to terminate contracts based solely on Star Ratings performance.

Additional Adjustment to Address Lack of an LIS Indicator for Enrollees in Puerto Rico
(p. 133)

For 2019, CMS proposes to continue to employ two additional adjustments for Puerto Rico in recognition of the unique challenges faced by MA plans operating on the island: 1) approximating LIS-eligible beneficiaries to allow Puerto Rico-based plans to be eligible for adjustments under the CAI, and 2) implementing a differential weighting scheme for the medication adherence measures for these organizations in calculating the Overall and Summary Star Ratings. AHIP appreciates CMS's ongoing recognition of the specific circumstances faced by plans operating in Puerto Rico and strongly supports the agency in continuing to implement these adjustments.

Disaster Implications (pp. 133-140)

CMS proposes to adjust the 2019 and 2020 Star Ratings to consider the effects of disaster events that occurred during the 2017 performance period. Contracts that meet the proposed criteria for an "affected contract" (service area is within emergency area during emergency period as defined by Section 1135(g) of the Social Security Act, service area is within Stafford Act declaration of a major disaster area, and enrollee(s) reside in a Federal Emergency Management Agency (FEMA)-designated Individual Assistance Area) would be eligible for adjustments. CMS further indicates that contracts operating solely in Puerto Rico would be treated as affected contracts without further analysis due to the extent of damage in that area. CMS provides details regarding adjustments that would be made to CAHPS, HOS, HEDIS, and other Star Ratings measures for affected contracts. In addition, CMS proposes changes to cut point calculations to minimize impacts.

AHIP supports CMS's proposals to adjust the 2019 and 2020 Star Ratings to account for the effects of disaster events that occurred during the 2017 performance period. CMS should also ensure that affected plans are not disadvantaged due to the proposed Star Ratings adjustments. We also recommend that when setting cut points for Star Ratings measures, CMS ensure that both affected and non-affected contracts are not adversely impacted. We understand that the FEMA website may not be updated on a regular basis and so plans may have to rely on other official federal resources (e.g., Presidential disaster or emergency declaration) to determine their status under CMS's proposed criteria for "affected contracts." We therefore recommend that CMS ensure that its proposed new policy appropriately covers all federally recognized disaster areas.

New 2019 Display Measure (pp. 140-141)

Plan Makes Timely Decisions about Appeals (Part C). Currently, this measure which addresses the timeliness of appeals decisions excludes cases where appeals are dismissed or

withdrawn. CMS proposes to include a modified version of this measure on the display page for 2019 and 2020, which would include dismissed and withdrawn appeals.

While CMS suggests that excluding dismissed and withdrawn cases can cause plan performance to be “artificially improved,” we believe the agency should provide more details about its concerns and address withdrawn cases that are not under a plan’s control. In the absence of more information, including consideration of an approach that would account for the different sets of facts that could be relevant to dismissed or withdrawn cases, we recommend that CMS not move forward with this proposed change for the 2019 and 2020 display pages.

Changes to Existing Display Measures (pp. 141-144)

Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D). CMS proposes to add the Pharmacy Quality Alliance (PQA) measure, Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP) to the 2019 display page. CMS also indicates that it would continue to report all three PQA measures related to opioid use at high dosages and from multiple providers to Part D plan sponsors via the Patient Safety reports.

We support CMS’s proposal to include the OHDMP measure on the 2019 display page given that this measure aligns with the criteria used in the Overutilization Monitoring System (OMS). We also recommend that CMS evaluate the impact of the implementation of the voluntary Part D drug management program for high-risk beneficiaries on the OHDMP measure prior to considering the measure’s inclusion in Star Ratings.

Forecasting to 2020 and Beyond

Potential Changes to Existing Measures (pp.145-148)

Plan All-Cause Readmissions (Part C). CMS indicates that NCQA is considering a number of changes to this measure, including possible stratification of the Plan All-Cause Readmission measure or creation of a new measure to evaluate acute facility readmissions among Medicare beneficiaries during or after a skilled nursing facility stay for Medicare Advantage contracts. CMS welcomes feedback on the proposed changes to the measure.

We appreciate CMS’s request for input from stakeholders and encourage the agency to work closely with Medicare Advantage plans and other relevant stakeholders to assess the feasibility, usefulness, and burdens associated with changes to this measure, including reporting on and evaluating readmissions during or after a skilled nursing facility stay.

Telehealth and Remote Access Technologies (Part C). CMS solicits feedback on the feasibility of and strategies for addressing telehealth services, especially regarding the following

measures that are reported by Medicare contracts: Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Adults' Access to Preventive/Ambulatory Health Services, Controlling High Blood Pressure, and Comprehensive Diabetes Care.

AHIP supports the inclusion of telehealth encounters when clinically appropriate. We continue to recommend that CMS provide more details including an impact analysis and work with the industry to address all relevant issues, including adjustment of HEDIS and CAHPS measures to include telehealth, submission of telehealth encounter data and inclusion for risk adjustment.

Center for Medicare and Medicaid Innovation Model Tests. CMS indicates that it is considering the impacts of excluding MA-VBID model test participants' data when calculating the cut points for relevant measures. Also, CMS plans to analyze and evaluate potential adjustments, including establishment of different cut points for Part D Enhanced MTM Model participants.

We appreciate CMS's plans to assess ways to ensure that results from these model tests do not adversely impact Star Ratings for participants or non-participants in either model.

Potential New Measures for 2020 and Beyond (pp. 148-156)

Opioid Overuse (Part C). CMS indicates that for HEDIS 2018, NCQA is collecting data on Use of Opioids at High Doses and Use of Opioids from Multiple Providers. These measures are adapted from the PQA's opioid measures. CMS welcomes feedback from stakeholders about the value of including these Part C measures on the display page, given the similar Part D measures that constitute data for Patient Safety reports and which may also be reported on the display page. CMS also indicates that for HEDIS 2019, NCQA will be testing a new measure concept that addresses members who were previously naïve to opioids who become long-term or "chronic" users and is also considering testing of a second measure concept that addresses the concurrent prescription of opioids and central nervous system depressants.

Given the importance of combating the opioid epidemic, AHIP supports evaluation and consideration of opioid measures. We also appreciate CMS raising concerns with inclusion of duplicative opioid measures in the Star Rating system and recommend that the agency engage with stakeholders to determine the benefits and burdens associated with adopting these new measures. As indicated in our comments above, we believe an adoption strategy for new Star Ratings measures should be one of the focus areas addressed through the TEP.

Other Star Ratings Comments

Pre-Determined Cut Points. CMS does not currently establish pre-determined cut points for measures in advance of the measurement period. AHIP continues to urge CMS to: develop cut points and publish them well in advance of the measurement period; ensure that the cut points

reflect meaningful differences; and limit year-to-year cut point changes to minimize wide fluctuations. This approach enables plans and their network providers to set markers for quality improvement activities and goals. For value-based arrangements to work best, plans and providers need to assess and modify performance goals. Pre-determined cut points based on industry performance trends would enhance the ability of plans and their providers to set their own performance benchmarks and evaluate the effectiveness of their efforts to improve the quality of care and reduce costs while maintaining high rating levels. The setting of pre-determined 4-star thresholds also aligns with CMS's set of guiding principles set forth in the Medicare Advantage and Part D proposed rule for 2019 that calls for stability and transparency in the rating system.

Release of National Data During Plan Preview Period. As we mentioned in our comments to the Medicare Advantage and Part D proposed rule for 2019, AHIP recommends that CMS post national Star Ratings data during the second plan preview period. CMS expects Part C and Part D sponsors to closely review their measures data and the methodology to identify and alert CMS about issues or problems during the plan preview periods. Posting national Star Ratings data during the second plan preview period would ensure that sponsors have access to all the information they need for comprehensive review and evaluation of their Star Ratings data and help with identifying trends.

Volume of Star Ratings, Display and Future Measures. Given the volume and variety of measures in Star Ratings, on the display page, and being forecasted for 2020 and beyond, it is critically important that CMS focus efforts on developing a multiyear strategic plan for: adopting, maintaining, revising, and retiring measures in the Star Ratings program; determining which measures are most appropriate and avoid duplicative measures; assessing the reporting and other burdens of individual and collective measures in Star Ratings and on the display page; and assessing the impact of frequent changes of measure composition, specification, and thresholds on the ability of plans to design quality improvement programs. For example, CMS should assess stakeholder feedback on potential new measures such as the Transitions of Care, Adult Immunizations, and Anxiety measures, including industry comments regarding challenges and burdens in data collection and reporting. As indicated in our above-mentioned comments, we recommend that CMS direct the TEP to consider and provide recommendations on these programmatic needs and impacts.

Validation Audits (pp. 159-164)

CMS proposes to make several changes to the program audit validation process and indicates that these changes are based on input received from stakeholders. The proposed changes include: exclusion of Compliance Program Effectiveness (CPE) conditions in determining whether the threshold for a validation audit (which is more than five audit conditions) has been met; clarification that organizations can use the same independent auditing firm that they use for their annual external CPE audit for their validation audit under certain circumstances; requirement to

use a standardized validation work plan template (that would be subject to public review and comment); extension of the timeframe to complete a validation audit report and submit it to CMS from 150 to 180 days; and clarifications to the process for submitting validation audit reports and supplemental information.

AHIP supports these proposed changes and believes that these changes would promote consistency, efficiencies, and lessen administrative burdens. We have also identified the following related issues and request that CMS address them in the final Call Letter and through sub-regulatory guidance.

- Examples of Conflicts of Interest. As indicated above, we support CMS's proposal to permit organizations to select the same independent auditing firm that they use for their annual external CPE audit under certain circumstances. In the draft 2019 Call Letter, CMS provides a few examples of situations that would and would not pose conflicts of interest and encourages plans to reach out to the agency if they have questions about potential conflicts. We appreciate CMS's willingness to work with plans on a case by case basis and recommend that both parties work to resolve a potential conflict if feasible. We also recommend that CMS continue to share with plans examples of scenarios that would or would not pose conflicts of interest for further clarity and to ensure transparency.
- Extension Requests. Under the current program audit validation process, plans may request in writing an extension of the 150-day deadline to complete a validation audit and submit the related report to CMS. Current validation audit guidelines also indicate that the written request for an extension must include a new target submission date and a justification for why CMS should grant the extension. In the draft Call Letter, CMS does not state whether it would still permit plans to file an extension request under the proposed new 180-day timeframe. We support CMS's current guidance that allows plans to request an extension for completing the validation audit and filing the related report and recommend that CMS continue to permit extension requests under the proposed new timeframe.

Plan Finder Civil Money Penalty (CMP) Icon or Other Type of Notice (pp. 164-165)

CMS proposes to display an icon or other type of notice on Medicare Plan Finder (MPF) for organizations that have received a CMP, beginning with the 2019 Annual Election Period (AEP). CMS states on page 164 that this notice is "an effort to remain transparent with enrollees when sponsoring organizations receive a CMP for violations of program requirements." CMS further indicates that it would begin displaying the CMP icon (or other type of notice) on MPF for any organization that receives a CMP in 2018 or receives a CMP for a 2017 program audit.

We have serious concerns with CMS's proposal to include a CMP feature on MPF, which we believe would lead to beneficiary confusion and not promote an apples-to-apples comparison of

plans. We note that beneficiaries already have access to CMP information since CMS posts CMPs on its website. Given the concerns and issues described below, we oppose this proposal and recommend that CMS not adopt it in the final Call Letter.

- Complexity and Range of CMPs. CMS can levy CMPs for a wide range of compliance issues and the penalty amount of CMPs varies significantly due to CMS's complex calculation formula that involves a number of adjustment factors. Given the complexity and range of CMPs, we believe that beneficiaries would have a very difficult time assessing and using CMPs to compare plan options.
- Increase Beneficiary Confusion. MPF already includes a lot of detailed information about plans' quality, cost, and coverage that beneficiaries must navigate and consider. Adding CMPs to MPF would complicate (not enhance) beneficiary decision-making. A Kaiser Family Foundation (KFF) report that surveyed beneficiaries to assess their experiences for choosing and changing Medicare plans indicated that beneficiaries who used the MPF "found it confusing, lacking information, and poorly constructed for comparisons on their desired factors [cost, provider networks, and coverage]." ¹⁴ Adding CMPs would undoubtedly lead to more beneficiary confusion and frustration given current challenges faced by beneficiaries using MPF as described in the KFF study.
- Additional Concerns. We are also concerned that CMS does not address the length of time that the CMP icon or notice would be on display or how CMS would handle cases where a CMP has been levied but is under appeal.

Although we do not support CMS's proposal to display a CMP icon on MPF, AHIP does support enhancing the availability of information on MPF that would help beneficiaries assess plan choices and make an informed enrollment decision. We therefore continue to recommend that CMS develop a task force comprised of plans, beneficiary advocates, providers, and other stakeholders to develop solutions for improving MPF so that beneficiaries can better understand and compare plan options and select the plan that best meets their unique care and financial needs.

Enforcement Actions for Provider Directories (p. 165)

CMS reminds Medicare Advantage organizations that the agency's provider directory monitoring activities could result in "compliance and enforcement actions if non-compliance is detected." We continue to believe that CMS should consider that the validity and accuracy of Medicare Advantage organizations' directories is contingent upon receipt of updated and accurate information by providers. In both of its Medicare Advantage provider directory review reports, CMS indicates that one of the common reasons for the provider directory errors is provider group practices providing data to plans at the group level rather than at the individual provider level. Maintaining accurate provider directories is a shared responsibility that requires a

¹⁴ Jacobson, G. Swoope, C., Perry, M. Slosar, M., "How are seniors choosing and changing health insurance plans?" Kaiser Family Foundation. May 13, 2014.

commitment from both health plans and providers to ensure consumers have the information they need and that the directory information is updated in a timely and accurate fashion.

AHIP and our members are committed to working with providers and other stakeholders to highlight the challenges to maintaining accurate and up-to-date provider directories, share strategies and best practices for maintaining and updating provider directories, and identify a national solution to this issue. We therefore continue to recommend that CMS's compliance and enforcement activities consider reasonable efforts made by Medicare Advantage organizations to obtain information from network providers and not penalize Medicare Advantage organizations when their providers fail to provide updated or accurate information in a timely manner.

Audit of the Sponsoring Organization's Compliance Program Effectiveness (pp. 165-166)

CMS proposes to provide relief for organizations undergoing a program audit by not requiring them to conduct an annual compliance program effectiveness (CPE) audit in the same year they undergo a CMS program audit. In addition, CMS is considering deeming organizations that have undergone a program audit as meeting the annual compliance program audit requirement for one year from the date of the CMS program audit.

We support these proposals and believe that they would minimize administrative burdens and eliminate duplicative compliance reviews.

Section II – Part C

Meaningful Difference (Substantially Duplicative Plan Offerings) (pp. 170-171)

CMS indicates in the draft Call Letter that through the Medicare Advantage and Part D proposed rule for 2019, it has proposed to eliminate the meaningful difference requirement beginning in 2019.

As we mentioned in our comments to the Medicare Advantage and Part D proposed rule for 2019, AHIP strongly supports and commends CMS's proposal to eliminate the Medicare Advantage meaningful difference requirement. This will increase market competition and give beneficiaries more opportunities to find plans that best meet their needs based on factors such as premiums, cost sharing, and provider networks. We also continue to recommend that CMS provide detailed guidance regarding the distinctions in plan options that would be permissible.

Total Beneficiary Cost (TBC) (pp. 171-173)

CMS proposes to increase the TBC change threshold for most plans from \$34.00 PMPM to \$36.00 PMPM in CY 2019. CMS also indicates that it is considering the elimination of the current TBC evaluation in future years.

We believe that CMS's proposal to retain the TBC standard in 2019 does not align with its current position on allowing uniformity flexibility and eliminating the meaningful difference requirement. The elimination of TBC would encourage plan innovation, competition, and further enhance plan offerings that are tailored to meet beneficiary healthcare needs. We therefore urge CMS to eliminate the TBC in 2019 and for subsequent years. Additionally, we encourage CMS to work with plans to identify alternative ways that the agency could address its concerns about the level of increases in a given plan's cost sharing or decreases in benefits from one year to the next.

Part C Cost Sharing Standards (pp. 176-180)

CMS indicates that for 2020, it is considering changes to its policies related to service category cost sharing limits. We welcome the opportunity to have a dialogue with CMS about potential changes to cost sharing limit policies to offer more flexible benefit options to enrollees.

Health Related Supplemental Benefits (pp. 182-183)

Under Section 1852(a)(3) of the Social Security Act, Medicare Advantage plans can offer supplemental benefits that are "healthcare benefits." CMS has interpreted this to mean that supplemental benefits can be offered only if they are "primarily health related." CMS intends to expand the scope of benefits that it interprets as being "primarily health related" starting in 2019. Under its new interpretation, CMS states on page 183 that "in order for a service or item to be 'primarily health related,' it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or conditions, or reduce avoidable emergency and healthcare utilization."

AHIP strongly supports this new interpretation of "primarily health related." This would allow plans to offer important benefits that, as CMS notes, can enhance quality of life and improve health outcomes.

We also note that the BBA includes a provision that allows for expanded supplemental benefits for individuals with chronic illnesses beginning in 2020. As part of this provision, CMS may waive the uniformity requirements in Part C of the Social Security Act. We believe that the BBA provision should be viewed as being complementary to CMS's preexisting interpretive authority about the scope of permissible supplemental benefits. That is, the BBA provision now ensures that MA plans must be permitted to offer expanded supplemental benefits to chronically ill beneficiaries beginning in 2020. However, the provision also indicates it applies "in addition to any supplemental health care benefits otherwise provided under this paragraph." We believe this allows CMS to exercise its interpretive authority to expand supplemental benefits beyond those in the BBA provision, including making them available in 2019, as long as the expansion does not involve the waiver of the uniformity requirements. We therefore urge CMS to finalize its proposal to apply its new interpretation for 2019, so Medicare beneficiaries may have the ability

to access a wider array of items and services to meet their individual needs. We also support CMS's intention to offer detailed guidance in advance of bid submissions.

Enhanced Disease Management (EDM) for Dual Eligible Special Needs Plans (D-SNPs) and Institutional Special Needs Plans (I-SNPs) (pp. 183-184)

CMS proposes to allow D-SNPs and I-SNPs to offer the EDM supplemental benefit that is currently available to non-SNP Medicare Advantage plans.

We support this proposal given that it would allow D-SNPs and I-SNPs to provide valuable services and care to their beneficiaries.

Medicare Advantage (MA) Uniformity Flexibility (pp.184-185)

CMS indicates in the draft Call Letter that through the Medicare Advantage and Part D proposed rule for 2019, it has interpreted statutory provisions and regulations to permit Medicare Advantage organizations starting in 2019 to lower cost sharing for benefits, offer tailored supplemental benefits, and offer lower deductibles for beneficiaries who meet certain objective clinical criteria. The benefit design would remain subject to a CMS determination that it is not discriminatory. In the draft Call Letter, CMS indicates that it will establish a special mailbox following issuance of the final Call Letter to answer questions regarding permissible flexibilities.

As we previously mentioned in our comments to the Medicare Advantage and Part D proposed rule for 2019, AHIP strongly supports and commends CMS for permitting Medicare Advantage plans to offer flexible, value-based benefit designs that encourage enrollees with chronic conditions to use high-value clinical services. This flexibility can promote better health and reduce costs by limiting utilization of low-value or unnecessary services. We continue to recommend that CMS provide further guidance as soon as possible about permissible flexibilities, including the offering of enhanced benefits and reduced cost sharing and deductibles. Additionally, we recommend that CMS provide guidance about the marketing rules for these new benefit designs as expeditiously as possible so that plans can effectively communicate with and educate beneficiaries.

We also continue to recommend that this new interpretation be extended to Part D benefits. We are not aware of any statutory or regulatory restrictions to extending this flexibility to Part D benefits. This extension would maximize health outcomes through improved care coordination and medication use.

Special Needs Plan (SNP) – Specific Networks Research and Development (pp. 185-186)

CMS indicates in the draft Call Letter its belief that the current Medicare Advantage network adequacy criteria and exception request process account for current beneficiary healthcare needs

and care delivery patterns but that it continues to examine the need for SNP-specific network adequacy evaluations and welcomes continued stakeholder feedback.

We continue to believe in the value and need for SNP-specific network adequacy criteria. We urge CMS to develop SNP-specific network adequacy criteria that are meaningful, not more restrictive than current Medicare Advantage requirements, and give health plans the flexibility to use innovative care delivery models, including telehealth services, to ensure access to providers who meet requirements unique to SNPs. AHIP also continues to recommend that CMS update the current Medicare Advantage network adequacy criteria and exceptions guidelines to account for the use of high-value provider networks, integrated care delivery systems and offering of personalized care access options, including telehealth services and other innovative care delivery models.

Rewards and Incentives for Completion of a Health Risk Assessment (HRA) (p. 186)

CMS proposes to permit Medicare Advantage plans to include the completion of an HRA as a permitted health-related activity under the Rewards and Incentives Program.

We support CMS's proposal and agree with the agency's rationale that completion of an HRA is a vital tool for care management, improved health and promotes the efficient use of health care resources.

Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs (pp. 187-190)

CMS highlights current D-SNP integration activities in the draft Call Letter. We support opportunities to promote integration and enhance beneficiary experiences. We commend the work CMS is doing in this area and encourage the agency to continue to work with states and plans to enhance those efforts.

Encounter Data Listening Forums, Monitoring and Compliance Activities (pp. 191-192)

CMS indicates in the draft Call Letter that it has initiated a series of listening sessions with Medicare Advantage organizations and plans to continue to hold these listening forums in 2018. CMS also provides a high-level overview of its framework for monitoring and compliance activities related to encounter data.

We support CMS's plans to hold additional listening forums to enable continued dialogue between the agency and plans on experiences with the submission of encounter data. However, we request that CMS make this process more transparent so that all plans and other stakeholders have greater opportunities for participation and learning. For example, CMS could publish

summaries of the listening sessions it hosts, such that all plans have a view into the types of issues with EDS that are being shared with CMS as well as CMS's response to those issues.

In addition, we request that CMS provide more detailed information to evaluate proposed monitoring and compliance measures in all future comment opportunities. We appreciate that CMS requested feedback on several proposed measures in November, but we were unable to fully assess and provide meaningful comment on the measures without more information. This information would include how peer groups were determined for each measure, what alternative peer groups were considered, and the distribution of scores used to determine thresholds for each measure overall and by numerous peer groups.

Given the ongoing technical and operational issues faced by the encounter data system, AHIP remains concerned with CMS's intention to begin enforcing encounter data performance measures through compliance actions. We continue to believe that initiating such compliance activities would be premature and recommend that CMS delay implementation of compliance activities until the challenges with the encounter data system have been successfully resolved.

Transparency & Timeliness with Prior Authorization Processes (p. 193)

CMS includes a provision in the draft Call Letter regarding permitted use of utilization management tools including prior authorization and reminds plans about applicable notice, timeliness and other requirements. We encourage the agency to work with plans to consider ways to improve the processes, promote quality, and reduce unnecessary burdens.

Other Part C Comments

Effect of Alternative Payment Model (APM) bonuses on Medicare Advantage county rates.

As we indicated in our comments on the calculation for the FFS benchmarks, CY 2019 is the first year that the MIPS payment adjustments will impact FFS payments and that the APM incentive payment that will be made to qualifying participants. We continue to request that CMS provide information about how FFS payment adjustments under the MACRA Quality Payment Program, including MIPS adjustments and APM incentive payments, will impact the benchmark rates that are used to determine monthly payments to Medicare Advantage plans.

MACRA Medicare Advantage APM Demonstration. CMS indicated in the MACRA CY 2018 final rule that the agency intends to develop a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative APMs under Medicare Advantage that qualify as Advanced APMs. We urge CMS to work with AHIP and other stakeholders to design and implement the demonstration.

Section III – Part D

Formulary Submissions

CY 2019 Formulary Reference File (FRF) (pp. 193-195). CMS proposes changes relating to the FRF, including a change to the summer formulary update window. The summer update window allows specified formulary changes to reflect the updated FRF that CMS publishes in advance of the window. CMS notes that the summer update window is the last opportunity, prior to the start of the plan year, for plans to remove brand drugs in favor of new brand and generic drugs included on the summer FRF. The update window for 2018 was open from July 27 to July 31, 2017. For 2019, CMS indicates it intends to push the window later into the summer, to include drugs introduced in July and August. In so doing, CMS requests feedback on the optimal submission window.

AHIP appreciates CMS's intent in considering a later update window. However, AHIP has heard concerns about the operational implications of a later window, including potential delays in the formulary approval process and difficulty in satisfying compliance and subsequent program deadlines.

Changes for CY 2019 Formulary Submissions (pp. 195-196). CMS proposes to change the 2019 formulary submission process by making the validation file for the Additional Demonstration Drug (ADD) file, which is submitted by Medicare-Medicaid Plans to reflect non-Part D drugs required by a state, available in advance of the ADD file submission deadline. CMS also proposes to remove the Non-Extended Day Supply (NDS) file requirement for CY 2019 and simplify the Over-the-Counter (OTC) Validation File.

AHIP appreciates and supports the proposed changes to streamline and simplify the formulary submission process for CY 2019. For example, removing the NDS supplemental file requirement would eliminate an operationally challenging and burdensome requirement that should also be removed for subsequent years.

Expanding the Part D Over-the-Counter (OTC) Program (pp. 196-197). CMS solicits feedback on allowing additional flexibilities for Part D plan sponsors to offer access to OTCs. For example, CMS could allow sponsors to include OTC products such as dietary supplements and cough medicines without meeting the current requirement that they offset the use of a Part D drug.

AHIP believes that such additional flexibilities would be appreciated by Part D beneficiaries and would provide sponsors the ability to provide better care for their enrollees.

Tier Composition (pp. 198-202)

CMS proposes a maximum threshold of 25% generic composition for the non-preferred brand tier that sponsors may choose to offer for CY 2019. CMS also states that sponsors that choose instead to offer a non-preferred drug tier will continue to have the flexibility to choose a cost-sharing structure that would be most appropriate for their benefit design. However, CMS also notes that it intends to conduct outlier tests for sponsors who choose a copay structure for the non-preferred drug tier and expects such sponsors to demonstrate value to beneficiaries through a written justification that includes information about the generic drugs on the non-preferred drug tier.

AHIP has concerns around the outlier tests that CMS intends to conduct. We request clarification on how CMS intends to identify and target sponsors, whether such tests would be limited to generics on non-preferred drug tiers, and more information about the rationale for conducting such tests.

Improving Drug Utilization Review Controls in Medicare Part D

Retrospective Drug Utilization Review

OMS Metrics (pp. 204-205). Beginning in the 2018 OMS reports, CMS proposes to change the Opioid Daily Dose measurement period from 12 months to 6 months and to add a second Opioid Daily Dose rate with a 90 MME threshold. These changes would align the report with 2018 OMS criteria. Additionally, CMS proposes to eliminate the 120 MME Opioid Daily Dose rate starting in the 2019 OMS reports.

AHIP appreciates CMS aligning and simplifying the different opioid measurement criteria that plans must manage and supports the changes proposed for the 2018 and 2019 OMS reports.

Opioid Potentiator Drugs (pp. 205-207). CMS proposes to add a concurrent opioid-gabapentin/pregabalin flag to alert Part D sponsors that concurrent use may be an issue that should be addressed during case management. CMS also solicits feedback from stakeholders on their experience with gabapentin/pregabalin, whether such a flag would be useful for sponsors, and other potentiator drugs that CMS should flag in the future.

AHIP supports the addition of the concurrent opioid-gabapentin/pregabalin flag to OMS as the concurrent use would increase the effects of opioids through its potentiating effect. AHIP also recommends that CMS consider adding the following potentiator drugs to the concurrent use flag in the immediate future - hypnotics, sedatives, and muscle relaxants. These drug categories have shown to potentiate the effects of opioids and thereby increase the potential for harm.

Concurrent Drug Utilization Review (DUR)

Cumulative Morphine Equivalent Daily Dose (MME) Safety Edits for High, Chronic Prescription Opioid Users (pp. 207-212). CMS proposes to require sponsors to implement a hard safety edit in 2019 when an opioid prescription triggers a beneficiary's cumulative morphine equivalent daily dose (MME) to reach or exceed 90 MME, in line with the Centers for Disease Control and Prevention (CDC) guideline. CMS further indicates that sponsors should not include multiple prescribers and/or pharmacy criteria but should continue to apply specifications to account for known exceptions such as hospice care and a cancer diagnosis.

CMS also proposes to allow a one-time 7-day supply of the opioid prescription that triggered the 90 MME hard edit so that patients would have time to pursue coverage through the exceptions process. Beneficiaries would not be allowed to obtain another 7-day supply for a prescription for another opioid after the hard edit is triggered. CMS solicits comments on how to best communicate to beneficiaries that the 7-day supply would no longer be available for future prescriptions as long as the MME level remains at or above 90 mg.

AHIP appreciates CMS taking steps to stem the overutilization of opioids in Medicare Part D. Our organization and members are also committed to implementing multiple strategies to combat the opioid public health crisis that has harmed countless people nationwide. For example, together with our plans, we launched the Safe, Transparent Opioid Prescribing (STOP) Initiative to support widespread adoption of clinical guidelines for pain care and opioid prescribing. The initiative includes the STOP Measure – a robust, evidence-based methodology health plans can use to measure how provider practices compare to the [Centers for Disease Control and Prevention \(CDC\) Guidelines for Prescribing Opioids for Chronic Pain](#). AHIP recently released the first nationwide benchmark data for the STOP Measure to show the health care industry's progress in collaborating with clinicians to address the opioid crisis and to identify specific actions that can be taken to reduce addiction and abuse. The initiative also includes the launch of a STOP Playbook. The Playbook provides practical examples of the various innovative health plan strategies encompassing prevention, early intervention, treatment, and recovery.

Further, in response to CMS's proposed rules for implementing Medicare lock-in provisions, AHIP supported the proposals but also offered targeted recommendations to provide plan sponsors with even more tools for addressing opioid misuse and abuse among Medicare beneficiaries. For example, AHIP advocated for the flexibility to implement prescriber lock-in programs without having to wait a proposed 6-month period.

Accordingly, AHIP supports the proposals providing for hard safety edits when a beneficiary's MME level reaches or exceeds 90mg, combined with a one-time 7-day fill. The hard safety edit at point of sale is a potent tool that should be available to plan sponsors to stem opioid misuse and abuse, especially when in line with CDC recommendations.

At the same time, we believe plan sponsors should have flexibility to customize opioid related safety and preventative measures specific to their enrollee populations. Sponsors can choose the extent to which they implement a drug management program that includes pharmacy or prescriber lock-ins. Similarly, we recommend that plan sponsors have the option of determining whether it is best to implement limits through a 90 MME hard safety edit at point of sale, or through soft edits that provide for pharmacists to engage the beneficiary on appropriate levels. This approach would provide stronger tools than currently available to sponsors, which are currently permitted to impose hard edits for MMEs above 200 mg.

Additionally, for those plans that choose to implement hard edits, we have concerns about operational challenges that may occur, including in connection with the 7-day fill. CMS therefore should ensure that plans choosing to implement a hard edit are not adversely impacted on other program requirements such as Star Ratings and the handling and reporting of complaints/appeals.

Lastly, AHIP believes that beneficiaries can be effectively notified of this change by a combination of standard language in the ANOC and EOC, and by the pharmacist at the point of sale.

Days' Supply Limits for Opioid Naive Patients (pp. 212-213). CMS expects that sponsors will implement a hard safety edit for initial opioid prescription fills that exceed 7 days when prescribed for acute pain. In so doing, CMS solicits feedback on any operational challenges for the hard safety edit, the potential addition of a 50 MME criteria, and other safeguards that may be needed.

AHIP supports the policy of limiting initial opioid prescription fills to 7 days or below and also implementing a 50 MME limit criteria. However, AHIP is concerned that defining an initial opioid fill may be operationally difficult, particularly for Part D plans without a complete history of the beneficiary (e.g., first-time enrollees to the plan). As such, we recommend that CMS provide a proposed definition and method of identifying an opioid naive patient or a first-time prescription for an opioid before finalizing any requirements. AHIP also notes that implementation of the proposal could involve significant changes and updates to systems and processes to address issues like identifying and processing exemptions from the 7-day limit (e.g., for people with cancer diagnoses). We therefore recommend that CMS ensure that sponsors have enough lead time to design and implement such requirements.

Opioid Duplicative Therapy Safety Edits (pp. 213-215). CMS expects sponsors to implement a soft POS safety edit when a patient receives duplicative long-acting (LA) opioid therapy beginning in 2019, with or without a multiple prescriber criterion. CMS also requests feedback on soft edit specifications.

AHIP supports the proposal. We also recommend that CMS continue to monitor the use of duplicative LA therapy and over duplication of short-acting (SA) and LA opioid therapy before proposing additional edits in the future.

Concurrent Use of Opioids and Benzodiazepines (p. 216). CMS proposes to require sponsors to implement a soft POS safety edit for concurrent opioid and benzodiazepine use.

AHIP supports the addition of a soft POS safety edit for concurrent opioid and benzodiazepine use. However, AHIP also believes that adding benzodiazepines to the list of frequently abused drugs within a Part D sponsor's drug management program would more effectively stem the concurrent use of opioids and benzodiazepines. This would align CMS efforts within OMS reports, soft safety edits, and sponsor driven case management.

Section IV – Medicare-Medicaid Plans

Formulary and Supplemental Drug Files (pp. 224-225)

As we have indicated in our comments above regarding changes for CY 2019 formulary submissions, CMS proposes to make the Additional Demonstration Drug (ADD) validation file containing non-Part D drugs available to Medicare-Medicaid Plans (MMPs) via CMS's Health Plan Management System (HPMS) in advance of the ADD File submission deadline starting for CY 2019.

We support this proposal given that it would streamline the submission process for integrated formularies. We also appreciate CMS's ongoing evaluation of possible additional efficiencies regarding the timing of the ADD file's completion.

We would also like to take this opportunity to applaud CMS's Medicare-Medicaid Coordination Office (MMCO) for its continuing efforts to integrate program benefits for individuals who are dually eligible for Medicare and Medicaid and improve federal and state coordination. The MMCO is clearly committed to refining and improving the MMP demonstrations with an end to improving outcomes and experiences for enrollees and reducing administrative burden for states and MMPs. We believe there are additional opportunities for the Center for Medicare and the MMCO to work together to identify additional Medicare requirements that might be modified to further enhance the integration of services as experienced by enrollees. We continue to recommend enhanced intra-agency coordination in the design and oversight of programs impacting dual eligibles, under the leadership of the MMCO, so that decisions affecting these programs are made through the lens of an integrated program that considers the impact on beneficiaries, as well as coordination with state partners and MMPs.

MEMORANDUM

To: AHIP
From: Epstein Becker & Green, PC¹
Date: March 2, 2018
Re: Calculating Medicare Advantage Adjusted Average Per Capita Cost

I. Executive Summary

The question presented is whether, for the purposes of setting Medicare Advantage (“MA”) payment rates, the expenditures of Medicare beneficiaries enrolled only in Part A should be excluded when calculating adjusted average per capita cost (“AAPCC”) under a reading of the plain language of the Medicare statutory text.

The statute requires the Centers for Medicare & Medicaid Services (“CMS”) to calculate MA payment rates based on a percentage of the adjusted average per capita Medicare fee-for-service (“FFS”) expenditures, also known as the AAPCC, from each county. CMS currently calculates the AAPCC by totaling all FFS expenditures under Part A, totaling all FFS expenditures under Part B, and adding the two figures together. This method captures the expenditures of *all* Medicare beneficiaries, regardless of whether they are the 86.8 percent of beneficiaries enrolled in *both* Parts A and B, the 12.4 percent enrolled in Part A *only*, or the 0.8 percent enrolled in Part B *only*.²

MA plans are required to provide coverage for all services included under *both* Parts A and B. The Medicare Payment Advisory Commission (“MedPAC”) has concluded that “certain counties are likely to have MA benchmarks based on FFS spending [that are] inaccurately measured” under CMS’s current calculation of AAPCC in light of CMS’s current inclusion of costs attributable to beneficiaries enrolled only in Part A.³ According to MedPAC, “it may be more equitable” if CMS were to exclude beneficiaries enrolled only in Part A from its AAPCC calculations used for MA benchmarks.⁴ MedPAC has recommended that “[t]he Secretary should calculate Medicare Advantage benchmarks using fee-for-service spending data only for beneficiaries enrolled in both Part A and Part B.”⁵ CMS, itself, came to a similar conclusion following a review of 2009 FFS costs in Puerto Rico that found “the per capita costs for beneficiaries enrolled in both Part A and Part B were higher than those enrolled in Part A and/or

¹ This memorandum has been prepared by Philo D. Hall, Associate, Thomas E. Hutchinson, Strategic Advisor, and Lynn Shapiro Snyder, Senior Member of the Firm.

² See MedPAC, Report to the Congress: Medicare Payment Policy, table 13-8, pg 360 (Mar. 2017).

³ *Id.* at pg. 362.

⁴ *Id.*

⁵ *Id.* at page 362.

Part B.”⁶ The discrepancy was used by CMS at the time as a rationale in concluding that “establishing the FFS rate in Puerto Rico based on enrollees in both Part A and Part B is a reasonable approach.”⁷

What follows is the statutory language establishing the methodology for calculating AAPCC and for calculating the payment rates for MA plans, including its reference to AAPCC, along with a reading of the statutory language. We provide reference to applicable canons of statutory construction and cite to relevant case law. In summary, a reading of the plain language of the Medicare statutory text is that Medicare Part A only beneficiary cost data should be excluded when calculating Medicare Advantage payment rates based on AAPCC.

II. Statutory Scheme for Medicare Advantage Payments Bases Payments on Average FFS Expenditures as Calculated Under AAPCC

A complex formula is outlined in the statute to determine the monthly payments made by CMS to MA plans for providing coverage to MA enrollees. The Social Security Act provides that MA plans receive monthly advance payments from CMS with respect to coverage of enrolled individuals for a month.⁸ Those payments are determined by comparing an MA plan’s bid estimating the revenue that an MA plan needs for required Medicare Part A and Part B covered services to a benchmark established in statute and calculated by CMS.⁹

That benchmark is known as the “MA area-specific non-drug monthly benchmark amount,” which, since 2012, is defined as “1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year.”¹⁰ The “blended benchmark amount” represents a percentage of the average per capita Medicare FFS expenditures for the “area” and year, and subsequent to 2012, is calculated by multiplying the “base payment amount” specified under subparagraph 1853(n)(2)(E) by the “applicable percentage” specified under subparagraph 1853(n)(2)(B).¹¹

The “base payment amount”, in turn, for a rebasing year subsequent to 2012, “is specified under subsection (c)(1)(D) for the area for the year.”¹² Subsection 1853(c)(1)(D) is as follows:

100 percent of fee-for-service costs. (i) In general. For each year specified under clause (ii), the *adjusted average per capita cost* [(“AAPCC”)] for the year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payment under sections

⁶ Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, Centers for Medicare & Medicaid Services, pg. 29 (April 4, 2011).

⁷ *Id.*

⁸ SSA § 1853(a)(1)(A)(ii).

⁹ *Id.* at § 1853 (a)(1)(B); 42 CFR § 422.304(a).

¹⁰ SSA § 1853(j)(1).

¹¹ *Id.* at § (n)(1)(B), (n)(2).

¹² *Id.* at § (n)(2)(E)(ii).

1848(o) [incentives for adoption and meaningful use of certified electronic health record (EHR) technology for physicians], 1886(n) [incentives for certified EHR technology for hospitals] and 1886(h) [direct graduate medical education costs of hospitals]. (emphasis added)¹³

At first impression, it may appear that CMS has a statutory obligation to follow the heading of subsection 1853(c)(1)(D) and calculate the “base payment amount” as “100 percent of fee-for-service costs.” However, the canons of statutory construction hold that “headings and titles are not meant to take the place of the detailed provisions of the text”¹⁴ and can provide little interpretive aid. A heading or title can shed light on a section’s basic thrust,¹⁵ or on ambiguous language in the text, but it “has no power to give what the text of the statute takes away.”¹⁶ The heading or title “cannot limit the plain meaning of the text.”¹⁷ The corollary is that a heading or title also cannot broaden the plain meaning of the statutory text.

In other words, in order to determine CMS’s flexibility to calculate MA benchmarks using only FFS costs attributable to beneficiaries enrolled in both Parts A and B, the focus should be on the statutory language of subsection 1853(c)(1)(D), itself, and not on the heading of this subsection. The language therein outlines that the “base payment amount” is determined by the AAPCC as “determined under section 1876.”

Section 1876 was amended by the “Tax Equity and Fiscal Responsibility Act of 1982”¹⁸ which first established AAPCC and defined it under section 1876(a)(4) as follows:

[t]he average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under *parts A and B, or part B only*, and types of expenses otherwise reimbursable under *parts A and B, or part B only* . . . if the services were to be furnished by other than an eligible organization . . . (emphasis added)

Significantly, absent from this provision is an option to calculate AAPCC with costs under *Part A only*. Instead, the only two enumerated options for calculating AAPCC are costs under “parts A and B” or “part B only.” Therefore, under a reading of the plain language

¹³ Clause (ii) identifies rebasing years. In years that are not rebasing years, the base payment amount is the amount for the previous year, increased by the national per capita MA growth percentage described in 1853(c)(6) for the succeeding year. SSA § 1853(n)(2)(E)(ii)(I).

¹⁴ *Trainmen v. Baltimore & Ohio R.R.*, 331 U.S. 519, 528 (1947).

¹⁵ See, e.g., *Almendarez-Torres v. United States*, 523 U.S. 224, 234 (1998); *INS v. National Center for Immigrants’ Rights*, 502 U.S. 183, 189 (1991).

¹⁶ *Demore v. Kim*, 538 U.S. 510, 535 (2003) (O’Connor, J., concurring) (citing *INS v. St. Cyr*, 533 U.S. 289, 308-09 (2001)).

¹⁷ *Trainmen v. Baltimore & Ohio R.R.*, 331 U.S. 519, 529 (1947); *Intel Corp. v. Advanced Micro Devices, Inc.*, 542 U.S. 241, 256 (2004) (quoting *Trainmen*).

¹⁸ Pub. L. 97-248.

Medicare statute, Medicare Part A only beneficiary cost data should be excluded when calculating Medicare Advantage payment rates based on AAPCC.

III. Excluding Data Attributable to Beneficiaries in Part A Under a Reading of the Plain Language of the Statutory Text

a. The Plain Terms of Statutes are Interpreted According to Their Ordinary Meaning

In *Chevron v. Natural Resources Defense Council*, the Supreme Court set out a two-step process for the interpretation of regulatory statutes: “First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.”¹⁹

For the purposes of construing the intent of Congress, “we start, of course, with the statutory text, and proceed from the understanding that unless otherwise defined, statutory terms are generally interpreted in accordance with their ordinary meaning.”²⁰ Further, when the statutory text is “plain, . . . where the disposition required by the text is not absurd [the court will] enforce it according to its terms.”²¹

The statutory interpretive canon, *expressio unius est exclusio alterius*, states that “expressing one item of [an] associated group or series excludes another left unmentioned.”²² An essential ingredient of an expression-exclusion demonstration is a “series of terms from which an omission bespeaks a negative implication.”²³ When applying these statutory interpretation rules to the issue presented, one can see that by authorizing the calculation of amounts payable for “services covered under parts A and B, or part B only,” but not for Part A as well, Congress made a deliberate and unambiguous choice to omit the calculation of Part A only amounts.

b. Section 1876 Excluded Part A Only Data from AAPCC Because the Relevant Health Plans Excluded Coverage for Part A Only Beneficiaries

Under section 1876(a)(4) as originally enacted by Congress, AAPCC was to be calculated for the costs of Medicare “parts A and B, or part B only,”²⁴ because the costs of coverage were to be projected for enrollees under the two authorized classes of plan coverage: “only those services covered . . . for those members entitled to benefits under part A . . . and enrolled under part B of this subchapter, or only those services covered under part B . . . for those members enrolled only under such part.”²⁵ Eligibility for these 1876 plans was limited to

¹⁹ 467 U.S. 837, 842-43 (1984) (citations omitted).

²⁰ *Sebelius v. Cloer*, 569 U.S. ___, No. 12-236, slip op. (May 20, 2013) (internal quotation marks omitted).

²¹ *Hartford Underwriters v. Union Planters*, 530 U.S. 1, 6 (2000) (internal quotation marks omitted).

²² *United States v. Vonn*, 535 U.S. 55, 65 (2002).

²³ *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 81 (2002).

²⁴ SSA § 1876(a)(4).

²⁵ *Id.* at § 1876(c)(2)(A) (emphasis added).

only individuals “entitled to benefits under part A . . . *and* enrolled under part B . . . *or* enrolled under part B of this subchapter only.”²⁶ Beneficiaries entitled to benefits under Part A only, but not enrolled under Part B, were not eligible for coverage under section 1876 plans. Nor are such Part A only beneficiaries eligible for coverage under the newer MA plans.

c. Congress Bypassed Existing Statutory Options to Base MA Benchmarks on Part A Only and Part B Only Cost Calculations

When Congress enacted the Medicare+Choice program as a part of the Balanced Budget Act of 1997, it chose to use AAPCC to establish capitation rates through the cross reference to section 1876(a)(4). Therefore, the AAPCC applies to the Medicare Advantage program.²⁷ Significantly, there are other sections of the Medicare statute that authorize the calculation of costs attributable to Part A only and Part B only beneficiaries.²⁸ If Congress had wanted to require the inclusion of Part A only attributable costs into the calculation of capitated rates when enacting the Medicare+Choice program, Congress could have directed the Secretary to combine the amounts calculated for Part A only under section 1818(d) and for Part B only under section 1839(a), each with a county specific adjustment, in such calculation. Instead, Congress tied the benchmark to the existing statutory language in section 1876(a)(4) which encompasses amounts attributable to those beneficiaries enrolled in both Parts A and B or Part B only.

d. The Plain Language of the Text of Section 1876 is Consistent with the Purposes of the MA Program.

It makes sense that Congress would adopt the AAPCC methodology to calculate costs to MA plans, as Congress requires those MA plans to provide coverage of “those items and services . . . for which benefits are available under parts A and B to individuals entitled to benefits under part A *and* enrolled under part B.”²⁹

Further statutory examples of Congress defining the scope of the MA program to encompass both Parts A and B include payments to MA plans with respect to enrollees under subsection 1851(i)(1) “shall be instead of the amounts which (in the absence of the [plan] contract) would otherwise be payable under parts A *and* B.”³⁰ When disseminating information to beneficiaries about coverage under the MA program, the Secretary is required by subsection 1851(d)(3)(A) to provide a “general description of the benefits covered under the original medicare fee-for-service program under parts A *and* B.”³¹ The MA quality and performance

²⁶ *Id.* at § 1876(d) (emphasis added).

²⁷ *See* Pub. L. 105-33 § 4001.

²⁸ For the individuals who are not otherwise entitled to Part A through the payment of at least 40 quarters of Medicare taxes, the Secretary is authorized to provide a buy-in for Part A only coverage, the premiums for which are calculated to be the monthly actuarial rate of national benefits and costs payable from the Federal Hospital Insurance Trust Fund for services to individuals age 65 and over. (*see* SSA § 1818(d)). Similarly, for individuals who elect coverage under only Part B, Congress authorized the Secretary to calculate Part B premiums based on the “benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed . . . with respect to such enrollees.” (*see* SSA § 1839(a)).

²⁹ SSA § 1852(a)(1)(B) (emphasis added).

³⁰ (emphasis added).

³¹ (emphasis added).

indicators provided to beneficiaries under subsection 1851(d)(4)(D) are intended to demonstrate how benefits under the plan “compare to such indicators under the original medicare fee-for-service program under parts A *and* B.”³² For the first 45 days of a year, subsection 1851(e)(2)(C) authorizes MA enrollees to “change election [into MA], but only with respect to coverage under the original Medicare fee-for-service program under part A *and* B.”³³ Continuous MA open enrollment for 2007 was limited under subsection 1851(e)(2)(E)(ii) to MA eligible “unenrolled fee-for-service individuals[s]” who were defined as those “receiving benefits under this title through enrollment in the original medicare fee-for-service program under parts A *and* B.”³⁴

e. Towards a Consistent Interpretation of the Language “Parts A and B” in the Section 1876 and the MA Statute

The statutory provisions enacted in 1997 that created the Medicare+Choice program³⁵ extensively, repeatedly and consistently use the language “parts A and B” when referring to the scope of the program. This buttresses the interpretation that CMS is permitted to exclude the costs attributable to beneficiaries enrolled in Part A only when calculating MA benchmarks.

By calculating the MA benchmark using FFS spending data from beneficiaries enrolled in either Part A *or* Part B, along with data from beneficiaries enrolled in both Parts A *and* B, CMS is interpreting the words “parts A and B” under section 1876(a)(4) differently than when CMS interprets those words in other parts of section 1876, and differently than when CMS interprets those words under sections 1851 and 1853. Normally, “identical words used in different parts of the same Act are intended to have the same meaning.”³⁶ Absent an alternative construction, a plain meaning of section 1876(a)(4) with respect the phrase “parts A and B” should have the same meaning when the phrase is used in different, but closely related, places in the MA program statute.

IV. Conclusion

For the reasons stated above, under a reading of the plain language of the statutory text cited above, Medicare Part A only beneficiary cost data should be excluded when calculating Medicare Advantage payment rates based on AAPCC.

³² (emphasis added).

³³ (emphasis added).

³⁴ (emphasis added).

³⁵ The precursor to the current MA program.

³⁶ *Sorenson v. Sec'y of Treasury*, 475 U.S. 851, 860, 106 S.Ct. 1600, 89 L.Ed.2d 855 (1986) (quotation marks omitted); see also, e.g., *Powerex Corp. v. Reliant Energy Servs., Inc.*, 551 U.S. 224, 232, 127 S.Ct. 2411, 168 L.Ed.2d 112 (2007) (“A standard principle of statutory construction provides that identical words and phrases within the same statute should normally be given the same meaning.”); *IBP, Inc. v. Alvarez*, 546 U.S. 21, 34, 126 S.Ct. 514, 163 L.Ed.2d 288 (2005) (noting that “identical words used in different parts of the same statute are generally presumed to have the same meaning”).