March 2, 2018

Submitted via the Federal eRulemaking Portal: http://www.regulations.gov

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2017-1063
200 Independence Avenue SW
Washington, DC 20201

Re: Comments on Part I and Part II of the 2019 Medicare Advantage and Part D Advance Notice and Draft Call Letter

Dear Administrator Verma:

Thank you for the opportunity to submit comments on the Advance Notice of Methodological Changes for CY 2019 for the MA CMS-HCC Risk Adjustment Model (Part I) and the Advance Notice of Methodological Changes for CY 2019 for MA Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter (Part II), published by the Centers for Medicare & Medicaid Services (CMS) on December 27, 2017, and February 1, 2018, respectively.

As one of the leaders in providing and managing benefits for Medicare and Medicaid beneficiaries, Aetna is committed to working with CMS and the U.S. Department of Health and Human Services to formulate rules that advance consumers' top priorities: care quality, affordability, and choice. We greatly appreciate CMS' responsiveness to the feedback provided on the most recent Request for Information and the Medicare Part C and D Proposed Rule (Proposed Rule). Aetna believes we should be building health care around beneficiaries and measuring quality based on their expectations of a healthier, more active life than that of their parents. To do that, we believe it is crucial to have policies that both preserve beneficiary choice and ensure that seniors have adequate access to coordinated care.

Specifically, we recommend:

- Employer Group Waiver Plans (EGWPs): We strongly recommend CMS take steps to minimize disruption to the EGWP program in order to help employers maintain this seamless form of coverage to their retirees. As detailed in the attached report (Attachment A),[1] EGWPs, particularly EGWP Preferred Provider Organizations (PPOs), allow MA plans to offer consistent coverage and benefits across the country, enabling employers to fulfill the promises they made by enabling their retirees to access the same level of coverage they came to rely on while they were active employees, regardless of where they live.

[1] Aetna, The Future of the Medicare Advantage Employer Group Waiver Plan Market (2018).

To maintain predictability and stability for the 4.1 million retirees who receive their Medicare coverage through EGWPs, CMS should implement a simple adjustment that takes into account the difference in Health Maintenance Organization (HMO) and PPO benefit structures within the EGWP market, ensuring that EGWP HMOs are not over-paid and EGWP PPOs are not under-paid. We also urge CMS to continue with a gradual phase-in over the next two years, placing more weight (e.g., 75%) on individual bid ratios in 2019, and fully phasing in the use of individual bid ratios in 2020.

As we outline in greater detail in the addendum, we believe this approach is actuarially sound, would mitigate adverse impacts to beneficiaries living in rural areas, and could help by preventing more beneficiaries shifting from MA EGWPs to Medigap.

- Benefit Flexibility: We applaud CMS' efforts to provide more flexibility in the Proposed Rule, and we greatly appreciate CMS reinforcing in the Advance Notice the reinterpretation of the uniform benefit requirements and expanding the scope of what is considered "health related" supplemental benefits. We continue to believe this flexibility will provide us the ability to design condition-specific programs that encourage beneficiaries to receive the necessary care and assist them in managing their chronic conditions. We were pleased to see Congress pass the Senate's Chronic Care Act, as part of the recently enacted Bipartisan Budget Act of 2018. We strongly support the flexibility included in this legislation and proposed by CMS, and we believe this will help us be more responsive to our members' needs in 2019 and beyond. We strongly urge CMS to finalize these proposals for 2019 and issue related supplemental guidance as quickly as possible.

- Coding Intensity Adjustment: CMS should not make any changes to the current methodology and should maintain the statutory minimum adjustment for 2019. While we appreciate CMS' willingness to seek comment on alternative methodologies for the coding intensity adjustment, we urge CMS to provide stakeholders more time to consider the implications of any change.

- Addressing the Opioid Epidemic: CMS should finalize the proposed changes to address opioid abuse, including the 7-day limit on initial opioid fills and enhancing the overutilization monitoring system (OMS). However, we ask CMS to allow plans to do more to prevent opioid abuse. Specifically, we recommend allowing Part D plan sponsors to place point-of-sale (POS) edits on potentiator drugs and other drugs that enhance the effects of opioids (e.g., muscle relaxants and benzodiazepines) when the plan sponsor is aware that the enrollee also has a prescription for opioids. We also recommend CMS require Part D plan sponsors to implement the 90 Morphine Milligram Equivalent (MME) hard edit only when two or more providers are involved.

- Medicare Part D: We urge CMS to expeditiously issue guidance to plans on implementation of the newly enacted Part D provisions in the Bipartisan Budget Act of

2018.

We detail these recommendations, as well as additional comments on specific proposals, in the attached addendum. We would be happy to respond to any follow-up questions you may have.

Sincerely,

Steven B. Kelmar
Executive Vice President, Corporate Affairs
Aetna

Addendum
Detailed Comments on the Part I Advance Notice and the Part II Advance Notice and Draft Call Letter

We appreciate the opportunity to comment on the Part I Advance Notice and the Part II Advance Notice and Draft Call Letter. Our recommendations follow.

Part II Advance Notice and Draft Call Letter

I. Employer Group Waiver Plans (EGWPs)

Aetna appreciates the continued dialogue with CMS to move toward a payment methodology for EGWPs that is a function of individual MA bids, thereby eliminating the need for EGWP bids. However, we remain concerned about the impact of implementing the original flawed policy proposal that would make severe cuts to EGWP payments. With over 4.1 million EGWP beneficiaries today, we urge CMS to take steps to minimize disruption to the EGWP program and to help employers maintain this seamless form of coverage to their retirees. As detailed in the attached report (Attachment A),[2] EGWPs, particularly EGWP PPOs, allow MA plans to offer consistent coverage and benefits across the country, enabling employers to fulfill the promises they made to their retirees years ago. This framework allows retirees to access the same level of coverage that they came to rely on while they were active employees, regardless of where they live. Consistent coverage leads to better health outcomes and beneficiary satisfaction.

A. *Fix the HMO/PPO Adjustment*

As we have noted in prior comment letters, we disagree with the payment methodology proposed in the 2019 Advance Notice, which would fully phase in an EGWP payment methodology based on aggregate individual bid to benchmark ratios without regard to HMO/PPO differences. More information can be found in the attached Milliman report (Attachment B).[3] However, we are encouraged that CMS is considering modifications to this proposal. Specifically, CMS is considering modifications to incorporate an HMO/PPO adjustment and to continue with a partial phase-in consistent with 2017 and 2018. CMS' adjustment would, for each payment quartile:

- Calculate 2018 bid to benchmark ratios for individual HMO and PPO plans;
- Calculate a weighted average 2018 bid to benchmark ratio based on the industry mix of EGWP HMO and PPO business; and
- Use the resulting weighted average 2018 bid to benchmark ratio for purposes of calculating payments to both EGWP HMOs and EGWP PPOs.

[2] Aetna, The Future of the Medicare Advantage Employer Group Waiver Plan Market (2018).
[3] Milliman, Employer Group Waiver Plan Funding: Analyzing the Impact of Bid-to-Benchmark Ratios (Jan. 20, 2017).

While we appreciate that CMS is exploring alternatives, Aetna believes there are several flaws to CMS' approach, specifically:

- Lack of actuarial soundness: There is clear evidence that HMO bids and cost structures are materially and consistently lower than PPO bids and cost structures. Paying both EGWP HMOs and PPOs based on the same weighted average bid to benchmark ratio results in payments that are not aligned with their respective cost structures and, therefore, are not actuarial sound.
- Inequity among HMO and PPO plans: Related to the lack of actuarial soundness, paying both EGWP HMOs and PPOs based on the same weighted average bid to benchmark ratio would unfairly overpay EGWP HMOs and underpay EGWP PPOs.
- Negative impact on rural markets: The resulting underpayment for EGWP PPOs would have a disproportionate and negative impact on rural areas of the country outside of HMO networks, which EGWP PPOs primarily serve. If EGWP PPOs are underpaid, benefits and coverage choices for Medicare-eligible enrollees in rural areas will become more limited or, ultimately, disappear, thereby affecting beneficiary choice, enrollment, and employers.
- Inconsistency with individual market payment structures: In the individual market, individual HMOs are paid according to individual HMO bids and cost structures, and individual PPOs are paid based on individual PPO bids and cost structures. Paying both EGWP HMOs and PPOs based on the same weighted average bid to benchmark ratio would be inconsistent with the way individual market HMOs and PPOs are paid. While we understand that the group market differs from the individual market, we see no reason why this payment structure should differ between markets.
- Increase costs to the Medicare program: This policy change could lead employers to stop providing Medicare coverage to their retirees through MA EGWPs, and instead choose to provide a flat subsidy amount that retirees will use to purchase Medigap coverage. This would result in more beneficiaries enrolling in unmanaged Medicare fee-for-service, which has the potential to increase costs to Medicare and drive up utilization.

➢ **Recommendation: Implement an alternative HMO/PPO adjustment that takes into account the difference in the benefit structure of HMOs versus PPOs within the EGWP market, to ensure that EGWP HMOs are not over-paid and EGWP PPOs are not under-paid.** Specifically, for each payment quartile, CMS should:

- Calculate bid to benchmark ratios for individual HMO and PPO plans;
- Pay EGWP HMOs based on the individual HMO bid to benchmark ratio; and
- Pay EGWP PPOs based on the individual PPO bid to benchmark ratio.

This is a simple technical fix that would address the flaws present in the currently proposed HMO/PPO adjustment and would help mitigate the impacts of EGWP payment changes on retirees, particularly those enrolled in EGWP PPOs in rural areas.

B. *Continue the Partial Phase-In*

We understand that, for 2019, CMS is considering maintaining the EGWP payment methodology used for 2017 and 2018 that would, for each payment quartile, calculate a 50%/50% weighting of individual EGWP bid to benchmark ratios for purposes of calculating payments to both EGWP HMOs and EGWP PPOs. We agree with the concept of maintaining a partially phased-in approach for 2019. However, given the magnitude of the payment change to the EGWP market, combined with the volatility associated with the Health Insurer Fee (HIF) (which was suspended in 2017, in place for 2018, suspended for 2019, and uncertain for 2020 and beyond), we recommend that CMS maintain a more gradual phase-in, placing more weight on individual bid ratios.

- **Recommendation: Continue with a gradual phase-in, placing more weight (e.g., 75%) on individual bid ratios in 2019, and fully phase in the use of individual bid ratios in 2020.** We believe continuing with a gradual phase-in would be consistent with CMS precedent in other programs, where it has incrementally made material changes over time to maintain stability. Placing a greater weight on individual bid ratios for 2019 would position CMS to implement an EGWP payment methodology fully based on individual bid to benchmark ratios in 2020.

  Combining the gradual phase-in with the above HMO/PPO recommendation, we recommend that CMS finalize the following EGWP payment methodology for each payment quartile:

  - Calculate a 75/25 weighting of the 2016 individual HMO and EGWP HMO bid to benchmark ratios for purposes of calculating payments for EGWP HMOs; and
  - Calculate a 75/25 weighting of the 2016 individual PPO and EGWP PPO bid to benchmark ratios for purposes of calculating payments for EGWP PPOs.

II. Benefit Design

A. *Uniform Benefit Flexibility*

As we noted in our comments to the Proposed Rule, we greatly appreciate CMS' continued efforts to collaborate with MA plans to ensure they have the flexibility to customize innovations that ensure the most effective and efficient coverage for beneficiaries. We strongly agree that CMS has the authority to permit MA plans to offer specific tailored supplemental benefits, including lower cost sharing, and offer lower deductibles for enrollees who meet specific medical criteria, provided that similarly situated enrollees are treated the same ("tailored benefits"). Providing access to tailored benefits will help MA beneficiaries have access to certain added services within their benefits that are specific to their conditions, ultimately improving health outcomes, decreasing costs to beneficiaries, and decreasing costs in Medicare overall.

The Bipartisan Budget Act of 2018 expressly allows MA plans to offer these more flexible benefits beginning in 2020. Bipartisan Budget Act of 2018 § 50322, amending Social Security Act (Act) § 1852(a)(3). Fortuitously, because CMS already has the authority to permit MA plans to offer more flexible benefits to enrollees, CMS should finalize its proposal for 2019, thus offering MA plans certainty, and affording them the necessary lead time to make improvements for 2020.

We have already seen how tailoring benefits can help improve health outcomes for our beneficiaries through Aetna's value-based insurance design (VBID) demonstration program in Pennsylvania, where we offer our members with congestive heart failure (CHF) reduced cost sharing when they see primary care physicians and cardiologists. In addition, this VBID program goes further to increase adherence to health care services and medication by offering both a robust care management program and by reducing cost sharing for CHF beneficiaries for certain prescription drugs. These initiatives are aimed at preventing our beneficiaries with CHF from being re-admitted or having avoidable emergency visits. We therefore believe that CMS should extend these flexibilities to Part D prescription drug coverage.

- **Recommendations:**

  - **We reiterate our support for CMS finalizing an interpretation of the uniform benefit requirements that enables MA plans to offer tailored supplemental benefits and reduced cost sharing to beneficiaries based on their clinical conditions.** We strongly support CMS' proposed interpretation in the Proposed Rule and have long supported the flexibility to design plan benefit packages that are responsive to the health needs of our enrollees. In addition, we would advocate that CMS consider ways to provide MA plans the flexibility to make benefits in lieu of benefits substitutions to best enable the plan to meet the needs of each unique member, including social determinants of health, perhaps via a demonstration or pilot.

  - **Extend this flexibility to allow MA plans to reduce cost sharing for certain beneficiaries' Part D prescription drug benefits.** We urge CMS to extend tailored benefit design to Medicare Part D benefits as well. Beneficiaries with chronic conditions – the individuals this flexibility would help the most – are not only in need of health care services, but also must adhere to specific prescription drug treatment courses to manage their conditions. Medication is a critical part of most treatment plans, and the clinical benefit of effective medication adherence should not be ignored. Allowing this flexibility with respect to Part D benefits would help ensure beneficiaries adhere to critical medication, ultimately reducing the chances of more serious health issues.

  - **Confirm that MA plans may choose to apply these flexibilities to out-of-network benefits**. We urge CMS to clarify that the ability to vary cost sharing applies to out-of-network services as well, should a plan choose, as long as it is offered to all

beneficiaries with the same clinical conditions. It is particularly important for employer group MA plans that offer services under an extended service area waiver.

- **Permit MA plans to require beneficiaries to actively participate in programs tailored to their specific health conditions.** As we explained in our comments to the Proposed Rule, active beneficiary participation is necessary to ensure that they understand the programs in which they participate, and fully benefit from the additional program and services available to them.

B. *Supplemental Benefits*

We also strongly support CMS' stated intent to expand the scope of the primarily health related supplemental benefit standard. We agree that CMS has the authority to interpret "healthcare benefits" more broadly to permit MA plans to offer additional benefits as "supplemental benefits" as long as they are healthcare benefits. We are pleased that CMS will be issuing updated guidance regarding this issue. We reiterate our support for guidance clarifying that MA plans may offer supplemental benefits, including social support services, for their most medically vulnerable beneficiaries, because they directly impact the health of a beneficiary and thus could meet the statutory requirement of being a "health benefit."

- **Recommendation: We support CMS issuing guidance, with an opportunity to comment, that MA plans may offer a broader array of supplemental benefits, including meals and nutrition services, transportation, housing assistance, communications devices, wearables, and other benefits that could help improve health outcomes for these beneficiaries.** We look forward to working with CMS to design coverage with benefits that help beneficiaries where they need it most.

C. *Meaningful Difference for MA and Part D*

The Draft Call Letter reiterates CMS' intention as described in the Proposed Rule to eliminate the meaningful difference standard for MA and Part D enhanced alternative plans.

- **Recommendation: We urge CMS to finalize a meaningful difference standard for MA and prescription drug plans (PDPs) as soon as possible, prior to the date of the Final Call Letter (i.e., prior to April 2, 2018).** Current uncertainty could result in MA plans and PDPs pursuing potentially costly and unnecessary changes to formulary development, product design, and pricing at a late stage in the bid development process.

III. Coding Pattern Adjustment

For 2019, CMS proposes to apply the statutory minimum MA coding pattern adjustment of 5.90%. *See* Act § 1853(a)(1)(C)(ii)(III). CMS is considering multiple methodologies to inform its final

decision regarding the coding intensity factor for PY 2019, requesting feedback regarding the three methodologies have been released to date:

- Methodologies discussed in PY 2010 Advance Notice and Rate Announcement
- Methodology discussed in PY 2016 Advance Notice and Rate Announcement
- MedPAC's March 2017 Report to Congress: Medicare Payment Policy

CMS also solicits comment regarding whether stakeholders would prefer another methodology.

Aetna appreciates the opportunity to consider the coding intensity adjustment methods that CMS has outlined, but we believe that stakeholders need additional time to fully analyze how well the methods actually reflect coding pattern changes, rather than increased risk. Accordingly, we believe that, for 2019, CMS should not adopt any of the methods it has proposed and instead continue to operate the program as it has in the past. As we feel the methodology requires a reexamination and updating, we encourage CMS to work with stakeholders over the year to develop an accurate, fair, and effective method for addressing coding intensity, which can be implemented in the future.

In addition, we are aware that the American Taxpayers Relief Act of 2012 (P.L. 112–240, § 639 (2)) increased the 2018 minimum statutory coding pattern adjustment factor from 5.7 percent (as established in the Affordable Care Act (ACA)) to 5.9 percent. However, we believe the ACA-established minimum amount of 5.7 percent was more accurate because it relied on more current data (i.e., EDS submissions and ICD-10, as opposed to RAPS and ICD-9). While we know lowering the minimum coding pattern adjustment below the statutory minimum would take Congressional action, we believe CMS should keep it as low as possible for 2019, especially because a lower amount is more consistent with newer data. We also believe it is crucial for CMS to work with stakeholders to have a comprehensive understanding of the effects of the coding pattern adjustment before making any increases.

- **Recommendation: For 2019, maintain the minimum coding intensity factor of 5.90%, as required in statute, and work with stakeholders (e.g., through a working group) to determine how to determine this factor most appropriately in future years.** We look forward to collaborating with CMS on this issue.

IV. Star Ratings Program

Aetna firmly believes that the Star Ratings system and the linkage of Star Ratings to MA plan reimbursement have had a transformational effect on the MA marketplace. The Star Ratings program has demonstrated that having a consistent, shared set of quality metrics can drive swift quality improvement. However, Aetna has long advocated – and continues to advocate – for more transparency and stability in the program to allow MA plans to invest effectively in quality improvements and work with our network providers to align quality incentives throughout the

entire care continuum.

We commend CMS on committing to using notice and comment as a way to update and change the Star Ratings program moving forward and believe CMS will receive better and more comprehensive feedback as a result. We look forward to continuing to work with CMS on these important issues.

A. *New Measures for 2019*

The Statin Use in Persons with Diabetes (SUPD) measure should be added to Part D measures for 2019. However, we believe adding the Statin Therapy for Patients with Cardiovascular Disease to Part C measures would measure a similar population for the same outcome as the SUPD measure. Specifically, the Part D measure looks at any members who are considered to be diabetic (based on drug fills) who are between the ages of 40-75. Any one fill of any statin in the year meets the measure. The Part C measure looks at members with established cardiovascular disease (CABG, MI, Ischemic vascular disease, etc.) and if they are on high or moderate-dosed statins. By definition, diabetes is a cardiovascular risk equivalent, so inherently there will be a disproportionate volume of diabetics already in the Part C measure. Because of this, we feel that we are measuring the same population twice.

- **Recommendation: Finalize the SUPD measure in Part D, but do not finalize the Statin Therapy for Patients with Cardiovascular Disease in Part C.** As we have previously stated, we believe CMS should be working to eliminate overlapping measures, such as these, and any new measures should be focused on improving quality of care.

B. *Improving Measures for 2020 and Beyond*

We appreciate CMS' discussion on improving measures for 2020 and beyond. As we proceed, we urge CMS to continue to evaluate and share data with plans and other stakeholders, and to collaboratively evaluate the clinical impact of these proposals. Providing as much transparency into the process in advance of the measurement period will allow plans to align providers, vendors, and investments appropriately.

1. Opportunities to improve measures to further reflect health outcomes

Aetna does not believe that the Health Outcomes Survey (HOS) measures, particularly those regarding the improvement of physical and mental health, are measures that are designed to best reflect true health outcomes of the current Medicare population. As the Medicare population ages, performance in these measures over the last several years has remained steady (with no significant improvement). Thus, instead of scoring plans on improvement of these measures, we believe it is important for CMS to consider how measures could better capture patient outcomes.

- **Recommendation: CMS could consider testing new Star Ratings measures that**

include patient-centered and patient-reported outcomes, alternative or improved patient satisfaction measures, and new outcome measure categories. As we have previously recommended, CMS should test how to measure quality in ways that effectively capture the patient perspective and experience. We support testing measures to build an evidence base that can help MA plans focus on improving true quality.

We also continue to suggest that CMS consider segmenting the measures to capture both clinical outcomes and patient experience and access measures in the areas of highest importance to beneficiaries and the health care system. MA plans primarily serve age 65+ beneficiaries, and the quality measures within the Stars program should have relevance to the issues facing that population and the quality of care measures most critical to an aged and aging population. These measures should be identified and developed with meaningful input from the patient population, and could include, but are not limited to:

- Advanced illness/palliative/end-of-life;
- Multiple comorbidity outcome management;
- Limiting progression of disease for impactable conditions;
- Keeping individuals in-home and in-community.

In addition, we recommend that CMS reevaluate certain measures where MA plans consistently perform well. For example, most plans perform very well on the Diabetes Care – Kidney Disease Monitoring measure, having a spread of cut points between 1 and 5 Stars that is only about 6% (between 92%-98%). Most Part D plans perform well on the MPF Price Monitoring measure as well. Having cut points across such a small range – especially when the range reflects high performance – skews the Star Ratings in a manner that does not adequately reflect how well plans are performing. We do not believe that this type of clustering is in line with the Star Ratings program's goals of measuring quality accurately.

- **Recommendation: Reevaluate and retire measures where MA and Part D plans are typically performing so well that the cut points do not vary enough to reflect meaningful difference in quality.** We ask CMS to reevaluate the following measures:

  - Part C: Diabetes Care – Kidney Disease Monitoring
  - Part C: Adult BMI Assessment
  - Part D: MPF Price Monitoring

Aetna supports CMS' proposal to adjust Star performance for contracts that have been negatively impacted by natural disasters. We believe that the adjustment needs to be structured in a way that allows those impacted contracts to maintain stability in performance year over year rather decline specifically as a result of these disasters. However, the adjustment should not be a vehicle that results in an improvement to Star Ratings performance where the contract has not otherwise demonstrated improvement. In addition, those impacted contracts with 60% of more of

membership in FEMA-designated counties will also be removed from the clustering methodology that is used to set cut points. While, on the surface, it appears that this removal will eliminate outlier performance from skewing cut points, we also caution that this removal could have an unintended impact on cut point setting by removing those historically high or low performers from the evaluation.

- **Recommendation:** We respectfully request that CMS construct a model of the adjustment methodology (similar to what was done for CAI) so the industry can more accurately evaluate impact on performance both at the contract level and on the cut points.

C. *Consolidated Contracts*

We reiterate our support of the Proposed Rule's proposal to establish a Star Ratings methodology for consolidated contracts that leverages an enrollment-weighted average of surviving and consumed contracts' performance. This process will more accurately reflect performance and ensure that contract consolidations are not occurring as a mechanism to increase Star Ratings. We also appreciate CMS recognizing that contracts operated by the same parent organization are likely to share many administrative process and procedures. In addition, we believe that this policy would sufficiently implement the new provisions enacted by the Bipartisan Budget Act of 2018.

- **Recommendation: Finalize the proposal in the Proposed Rule.**

D. *Measure-Level Calculation Changes*

As we have previously requested, we ask CMS to establish a cut point process that limits fluctuations across measures. CMS should use its own Quality Improvement thresholds to establish these guardrails. Since large swings in cut points year over year create instability, we reiterate our support for a process where CMS looks across several years of performance and establishes guardrails within each measure, to ensure more stability and predictability in the cut points.

- **Recommendation: Base cut points on several years of performance, and establish guardrails to minimize annual fluctuations.** Specifically, we recommend that CMS pull forward its own definitions of significant change from the Health Plan Quality Improvement measure to act as the guardrail for the measure, and that the changes in cut points year over year do not exceed these thresholds.

V. Medicare Part D and Addressing the Opioid Epidemic

A. *Addressing the Opioid Epidemic*

We continue to support CMS' efforts to address the opioid epidemic, and we particularly appreciate CMS' proposal to implement patient-doctor-plan communication and new tools to prevent Part D enrollees from over-utilizing opioids (e.g., expecting Part D sponsors to place a 7-day limit on initial opioid fills). While we agree that opioids should be the initial focus of the new lock-in function, we reiterate our position that Part D sponsors should retain the ability to include other frequently-abused drugs, as they do with their current point-of-sale (POS) claims edits.

While we appreciate CMS' effort to identify non-opioid potentiator drugs, such as gabapentin, we believe merely identifying the use of potentiator drugs does not go far enough to prevent overutilization of opioids with potentiators.

- **Recommendation: Allow Part D plan sponsors to place POS edits on potentiator drugs and other drugs that enhance the effects of opioids (e.g., muscle relaxants and benzodiazepines) when the plan sponsor is aware that the enrollee also has a prescription for opioids.** While we are aware that potentiator drugs may have uses that are not intended to enhance the effects of opioids (e.g., gabapentin is approved as an anti-seizure medication), we believe allowing Part D plan sponsors to place POS edits on drugs that enhance the effects of opioids will help stem addiction and potential overdoses.

We agree with the 7-day POS limit. But we also believe the 90 MME hard edit should be coupled with an exception process. Particularly, we believe that a single provider prescribing over 90 MME should be excepted from the POS edit because that provider would almost certainly override the edit for his/her own prescription.

- **Recommendation: Require Part D plan sponsors to implement the 90 MME hard edit only when two or more providers are involved.**

The proposal to exempt individuals with cancer diagnoses from the limit is too broad of an exclusion because not all cancer patients are in pain that necessitates opiates. Moreover, on occasion, providers have asked Part D sponsors to place POS edits on beneficiaries with non-terminal cancer who are abusing opioids. We therefore believe that a cancer diagnosis alone should not be reason enough to exempt someone from being considered an at-risk beneficiary and receiving intervention he/she needs to prevent or stem opioid addiction.

- **Recommendation: Exclude individuals with active, malignant cancer from the definition of at-risk beneficiaries, and implement this requirement on a case-by-case basis through conversations between the Part D sponsor and the prescriber.** Narrowing the exemption for individuals with cancer would strike the appropriate balance between ensuring beneficiaries have access to drugs when needed, and preventing opioid addiction among certain individuals. We also believe the care management requirement should help ensure that beneficiaries are appropriately excluded and included.

B. *Medicare Part D*

1. Consent for Automatic Refills in Part D

We appreciate that CMS is considering modifying the requirement of Part D plan sponsors to obtain consent from beneficiaries to receive automatic refills of mail-order prescriptions. We agree that this required consent is burdensome for both plans and beneficiaries and creates an unnecessary barrier, particularly for maintenance or low-cost drugs. We think getting members their medications and removing the transportation/access barrier that many encounter when having to make trips to a brick and mortar pharmacy, will give us a better chance of improving their adherence and improving health outcomes.

- **Recommendation: Remove the requirement for Part D plan sponsors to obtain beneficiary consent before receiving automatic refills of all maintenance drugs.**

2. Implementation of the Bipartisan Budget Act of 2018

The Bipartisan Budget Act of 2018 included a number of positive Part D changes that will reduce beneficiary costs, cut Medicare spending, and lower premiums. These included:

- Requiring biosimilars manufacturers to participate in the Coverage Gap Discount Program;
- Reducing beneficiary cost sharing in the Coverage Gap to 25 percent in 2019; and,
- Increasing the mandatory Coverage Gap Discounts from 50 percent to 70 percent.

Because Part D plan sponsors need to begin incorporating these proposals into their bids immediately, we ask CMS to issue immediate guidance regarding how to implement these changes.

- **Recommendation: CMS should expeditiously provide guidance on implementing the Part D provisions included in the recently enacted Balanced Budget.**

Part I Advance Notice: CMS-HCC Risk Adjustment Model

I. Payment Condition Count Model

Aetna supports CMS' proposal to implement a payment condition count model. We agree that a payment condition count model is the more accurate of the proposals because it is a better predictor of high-risk health conditions, and it is more consistent with provider practices because it captures the conditions that are actually coded. The all-conditions model, in contrast, would add "noise" to the data by collecting codes (and adjusting payments) for conditions that are not severe and not chronic. In other words, the all-conditions model does not adjust for conditions that have

a material impact on beneficiary health and wellbeing. As a result, we support the provider condition count model.

We do note that each model proposed used different age and gender factors without explanation. We believe that, generally, age and gender factors should be constant across models, and that CMS should not adjust age and gender factors when using the payment condition count model.

- **Recommendation: Finalize the payment condition count model. Clarify why the age and gender factors differ in each proposed model in the Advance Notice.**

II. Social Determinants of Health in CMS-HCC Model

While two people could have the same health condition, their treatment frequency and adherence could vary greatly due to many factors. Some of these factors are social determinants of health. Social determinants of health are "[c]onditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[4] Social determinants of health fuel a deeper understanding of health risks and ability to proactively impact health outcomes. Integrating and applying data on these social risk factors can be used to create predictive models that can improve risk stratification and population healthcare management initiatives.

We have seen that many social determinants of health are already captured through ICD-10 Z codes.[5] Among these new Z codes is a series of codes related to potential hazards due to family and social circumstances impacting health status. These codes, along with new ICD-10 codes for 2018, are included as Attachment C. Incorporating these codes into the CMS-HCC model could lead to improved reporting of health outcomes, which could be used to better coordinate proactive care management to improve health outcomes, reduce costs, and improve patient satisfaction and retention. CMS should also consider that providers may need education and training in the appropriate use of these codes when submitting claims so such conditions are not only captured but also so plans can use these data elements to improve condition management and initiate proper care activities.

- **Recommendation: Consider including social determinants of health codes in the CMS-HCC model, particularly in conjunction with care coordination.** We believe that capturing this information would lead to better care coordination, which would improve health outcomes, reduce costs, and improve patient satisfaction.

III. Information Sharing and Patient Consent

[4] CDC, *available at:* https://www.cdc.gov/socialdeterminants/ (last updated Jan. 29, 2018); *see also* https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

[5] For FY 2018 codes, see CDC, ICD-10-CM Official Guidelines for Coding and Reporting FY 2018, Chapter 21, available at: https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf.

We understand and appreciate the importance of validating risk adjustment data based on physician coding. And we appreciate that certain mental health and substance use disorder codes will be added to the risk adjustment model. But we believe that current Department of Health and Human Services policies may hinder the accurate capture of these new conditions for risk adjustment purposes.

There is a potential conflict between Medicare organizations' and CMS' requirements with the federal laws protecting sensitive health information (and some states also have laws in this area). Specifically, SAMHSA's recent final rule regarding information sharing requires patient consent for providers to share "sensitive" information (e.g., information regarding mental health and substance abuse services). See Confidentiality of Substance Use Disorder Patient Records See 83 Fed. Reg. 239 (Jan. 3, 2018). While we appreciate the need for patient confidentiality and fully support efforts to ensure patients are comfortable accessing these services, we believe this rule could hinder data necessary to inform the RADV process. For example, providers may refuse to provide medical records, especially if beneficiaries refuse to consent to further disclosure of their medical information behind the provider's treatment, thereby affecting plans' abilities to obtain records, audit and verification of submitted claims, and coding. In addition, this may also affect both CMS and plans with RADV due to the need to obtain records. CMS should consider this and examine this issue more closely as it adds codes.

- **Recommendation:** Collaborate with both Medicare organization representatives and agencies such as SAMHSA to relax the confidentiality rule for CMS and MA organizations when obtaining records for plan operations, including for RADV purposes.

IV. Data Sources

CMS proposes to calculate risk scores by using 25% encounter data (EDS) and 75% RAPS data (as opposed to 15% EDS and 85% RAPS data for PY 2018). While we appreciate the transition to EDS, we believe CMS should include impatient RAPS supplementing EDS.

- **Recommendation: Finalize a transition from RAPS to EDS, and include inpatient RAPS supplementing EDS.**

Technical Comments

Page(s)	Topic	Sub-Topic	Description	Comments
160	Program Audits	Validation Audits	CMS currently requires sponsoring organizations that have more than five program audit conditions in their final audit report to hire an independent auditing firm to conduct a validation audit. CMS conducts the validation audits of sponsoring organizations that fall below this threshold. CMS is seeking comments on whether this threshold should be increased or decreased, or limited to conditions that may cause adverse impacts to beneficiaries.	Aetna supports the current methodology of five or more.
160-161	Program Audits	Threshold for Requiring an Independent Validation Audit	CMS proposes to modify the threshold used to determine when a sponsoring organization must hire an independent auditing firm. Specifically, CMS intends to exclude Compliance Program Effectiveness (CPE) conditions from the threshold calculation. The identification of CPE conditions in a program audit indicate weakness(es) in a sponsoring organization's compliance program and its ability to prevent, detect and correct Medicare Parts C or D program non- compliance and fraud, waste and abuse (FWA) in a timely and well-documented manner. As such, CPE conditions require a customized audit approach that specifically tests correction of the issue but usually requires a lower level of effort from auditors to determine if the non-compliance has been corrected. For this reason, we believe that it is appropriate to exclude these conditions from the threshold calculation. Sponsoring organizations with more than five non-CPE conditions cited in their final audit report will be required to hire an independent auditing firm. CMS will conduct the validation audits of sponsoring organizations that fall below this proposed threshold. As a result, we estimate that the number of sponsoring organizations that will be required to hire an independent auditing firm will decrease by approximately three percent.	Aetna supports this enhancement.
161	Program Audits	Threshold for Requiring an Independent Validation Audit	CMS also clarify that although we intend to exclude CPE conditions from the threshold calculation used in determining whether a sponsoring organization would be required to hire an independent auditing firm, the requirement to validate correction of CPE conditions would not be eliminated. Once a sponsoring organization meets or exceeds the threshold, thus requiring an independent audit, all conditions, including CPE conditions, identified during the program audit must be validated by the independent auditor. Likewise, if the sponsoring organization audit results are below the threshold, CMS will conduct the validation of all conditions, including CPE.	Aetna supports this enhancement.
161	Program Audits	Conflict of Interest Limitations on Independent Auditing Firms	Currently, when an independent validation audit is required, the sponsoring organization must ensure that the independent auditing firm is free of any conflicts of interest. Examples of conflicts of interest include consultants who provide management consulting to the sponsoring organization, assist the sponsoring organizations with audit-related operations, and/or assist with the correction of the sponsoring organization's audit conditions. However, consultants used by the sponsoring organization to conduct "mock audits", "pre-assessments" or prior independent audits, or those who have never provided consult or assistance with the correction of audit findings for the sponsoring organization are not considered to have a conflict of interest.	Aetna supports this clarification.
161	Program Audits	Conflict of Interest Limitations on Independent Auditing Firms	During the validation listening session, sponsoring organizations requested that CMS permit the use of the same auditing firm used for their annual external Compliance Program Effectiveness (CPE) audit for conducting the validation audit. We want to clarify that sponsoring organizations are not precluded from selecting the same independent auditing firm that is used for their annual external CPE audit, as long as the firm has not provided consulting services or assistance with the correction of audit findings. Sponsoring organizations with specific questions as to whether a potential conflict of interest exists should contact their CMS validation lead for individual guidance.	Aetna supports this clarification.
162-163	Program Audits	Required use of CMS Validation Audit Work Plan Template	Based on CMS's experience in reviewing validation audit work plans and industry input, we intend to create a validation work plan template that sponsoring organizations undergoing independent validation audits in 2019 would be required to submit. In accordance with the Paperwork Reduction Act of 1995 (the PRA), we intend to include the draft template in an upcoming Federal Register proposed information collection. CMS believes that a CMS specified standardized work plan template will facilitate consistency across all validation audits and may also help to standardize the cost of an independent audit and improve inter-rater reliability across independent auditors.	Aetna supports this enhancement.
163	Program Audits	Required use of CMS Validation Audit Work Plan Template	A requirement to attach the independent auditing firm's proposed audit report template. The validation report template should include, at a minimum, the auditing firm's identifying information, the validation audit's objective, scope, methodology, and summary of results. In addition, to ensure the independent auditor can attest to performing a complete and independent review, the report should include details of any new findings (i.e., those not included in the program audit report). For additional detail, please refer to CMS's current guidance document "Program Audit Validation Close-Out" that is located on the webpage referenced above. The report template must be submitted with the work plan template, for review and approval by CMS prior to submission of the final report.	Aetna supports this enhancement.

163-164	Program Audits	Timeframe to Complete Validation Audits	Currently, sponsoring organizations have 150 calendar days from the date that all of their program audit Corrective Action Plans (CAPs) are accepted by CMS to complete a validation audit and submit the independent audit report to CMS for review. During the validation listening session, commenters suggested that the current timeframe does not allow sufficient time to first remediate issues, then accumulate a sufficient "clean period" to use as the basis for validation testing. Other commenters stated that smaller sponsoring organizations, with fewer cases from which to draw, find it hard to complete meaningful validation testing in the allotted timeframe. Based on 2016 validation audit experience, CMS agrees with the commenters and intends to extend the timeframe by 30 days. Sponsoring organizations would have 180 days from the date that CMS accepts their program audit CAPs to undergo a validation audit and submit the independent audit report to CMS for review.	Aetna supports this enhancement.
164	Program Audits	Submitting Independent Audit Report to CMS	CMS is clarify that the sponsoring organization would continue to submit its independent auditing firm's validation report to CMS but would also be required to copy the independent auditor on the submission. The report should be submitted to CMS as received from the independent auditing firm (i.e., without modification by the sponsoring organization). CMS encourages sponsoring organizations to submit additional documentation addressing any concerns with, or rebuttals to, the auditor's report.	Aetna supports this clarification.
165-166	Compliance Program Effectiveness	Audit of the Sponsoring Organization's Compliance Program Effectiveness	CMS is considering allowing sponsoring organizations that have undergone a program audit to treat the program audit as meeting the annual compliance program audit requirement in 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F) for one year from the date of the CMS program audit. CMS is seeking comment on this. The one year time frame would allow sponsoring organizations to complete their CMS CPE program audit process and remediation before a new CPE audit is initiated by the sponsor to evaluate compliance performance. CMS also requests comments on how this will impact burden for sponsoring organizations undergoing a program audit. CMS believes that it will reduce burden on sponsoring organizations already undergoing a CMS program audit and will eliminate the duplication of effort.	Aetna agrees that CMS should consider ways to reduce burden on Plans that are undergoing a CMS Program audit that tests the Compliance Program Effectiveness (CPE) as part of the audit. For plans that are under audit, the annual third party assessment would be duplicative and burdensome. CMS Program Audit notices are typically distributed between March and September. A CMS Program Audit, that includes a subsequent Validation Audit, could take up to 48 weeks to complete. The current chapter requirement for Audit of the Sponsor's Operations and Compliance Program reads " Audits of the compliance program should occur at least annually". To reduce the burden to plans audited, and drive consistency in application for the plans, Aetna would propose the following: *If a Plan that receives a CMS program audit notice, they do not have to complete the third party assessment in the current year of when the CMS notice is received and for 1 subsequent year. This would level set it for all impacted plans. Additionally, we would propose that CMS apply this consistently to all plans undergoing a CMS program audit regardless of whether the program audit results in CARs or ICARs in the areas of CPE. This would mean even those plans that do not need to remediate any CPE findings would receive this exception.*
205-207	Improving Drug Utilization Review Controls in Medicare Part D	Opioid Potentiator Drugs	From 2015 to 2017, the rate of gabapentin users increased by 14% from 93 to 108 users per 1,000 Medicare Part enrollees based on 6-month measurement periods. Higher gabapentin use was observed among opioid users. From January to June 2017, there were 308 gabapentin users per 1,000 Part D chronic opioid users41, and 452 gabapentin users per 1,000 OMS potential opioid overutilizers.42 From January - June 2015 to January - June 2017, CMS observed a change in the percent of gabapentin users receiving very high (> 2,400 mg) doses among opioid users and chronic opioid users of 7.5% and 8.5%, respectively. CMS is concerned that the increase in gabapentin use and higher doses among opioid users may place beneficiaries at a higher risk for adverse events. These safety concerns extend to pregabalin, which is also a gapapentinoid. CMS proposes to add a concurrent opioid-gabapentin/pregabalin flag to OMS. CMS is requesting feedback from stakeholders about what their experience has been with the potential overuse of gabapentin and pregabalin with opioids, whether this additional flag would be useful for Part D sponsors, and how the case management approach could help with gabapentin/pregabalin-opioid misuse and also with other potentiators. Furthermore, we seek comment on other potentiator drugs that should be added to the OMS and the utility of adding such drugs that may increase the risk for overdose when used with opioids. As with concurrent benzodiazepine and opioid use, we expect that when sponsors perform case management, they would include the use of other drugs (e.g., gabapentin and pregabalin) that can potentiate the risk of overdose within the case management.	1) Aetna recommends CMS consider Muscle Relaxants or more specifically Carisoprodol as a potential risk factor with concomitant opiate use. This drug is frequently seen as part of a "cocktail" that consists of opiates, benzos and muscle relaxants. CMS PDE audit for non MAI recently, more discussion is needed with CMS on how to promote appropriate use for a drug that is considered a protected class agent based upon call letter comments about gabapentin off label use. CMS needs to more clearly explain what the expectation is for handling both a protected class drug but with off label use to balance CMS protected class and the need for transition and ongoing access vs. known off label use. 2) To date, all studies referenced support that gabapentin is not effective for low back pain and should be used with caution in adjunct therapies. The effectiveness only shown in partial seizures and postherpetic neuralgia. This is the first time Aetna is seeing such references in a call letter where a protected class agent is noted for off label use and would ask CMS to better define how plans should balance protected class drug status and requirement to only impact new starts with coverage for FDA and compendia supported logic and balancing this with CDC pain treatment guideline standards. See non opioid recommendations @https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf, suggesting a wider range of uses for these anticonvulsant agents. Ultimately this decision needs to be thought thru from a guidance, TMPA and Program Audit alignment, Formulary Bid validation, IRE and Plan perspective if the expectation is to target gabapentin off label use either at point of sale, retrospectively thru DUR or when ongoing therapy comes thru a Pre Cert or appeals process. Given that gabapentin use has increased from 108 users per thousand to now 308 per thousand (using 1st 6 months of 2017) data in call letter, and even higher use in the OMS population, need a plan sponsor and CMS aligned strategy that is supported by clinical practice and CMS regulatory expectations. 3)Are we likely to see more member-specific UM edits (MSUME) restricting member's access to these potentiator drugs as well? If so, Aetna could use additional CMS guidance on processing the resultant appeals (ex. approval criteria, when can we term and modify exception authorizations, when needed for effective case management, method for properly identifying cases on audit universes and for HPMS reporting, etc.)
211	Improving Drug Utilization Review Controls in Medicare Part D	Cumulative Morphine Milligram Equivalent Daily Dose (MME) Safety Edits for High, Chronic Prescription Opioid Users	CMS seeks feedback on whether all sponsors have the capacity to implement hard edits at 90 MME as well as the 7 days allowance proposal for 2019. CMS also requests comment on other solutions to address prescription opioid overuse while balancing access to medically necessary drug regimens and reducing the potential for unintended consequences.	Aetna recommends CMS consider the following: 1. Implementing hard edit for new starts only 2. Tapering schedule for patients adjusted to higher doses to avoid rapid withdrawal OR Instead of an edit for members already exceeding 90 MME, perhaps send an educational letter hoping to be more impactful without creating unnecessary barriers at POS 3. Incorporate prescriber count even if it is set at two. Any single prescriber should be aware of the risk of exceeding 90 MME 4. Apply this edit only to those providers who may have less knowledge of the potential opiate issue i.e. Dentists, PACs, NPs, ER.

213	Improving Drug Utilization Review Controls in Medicare Part D	Days Supply Limits for Opioid Naïve Patients	CMS expects all Part D sponsors to implement a hard safety edit for initial opioid prescription fills that exceed 7 days for the treatment of acute pain. CMS understands that implementing such restrictions may create important challenges. Any restrictions should not compromise appropriate pain treatment or result in an excessive burden on clinicians and their patients. CMS requests feedback from stakeholders, especially Part D sponsors, providers, and PBMs, on the implementation of a days supply limitation at 7 days or if an alternative days supply limit would be more appropriate (such as 3 days or 5 days), including their experience with such limitations or the basis for their recommendations. We also solicit comment on whether a days supply limit with or without a daily dose maximum (e.g., 50 MME per day) would be more effective. In particular, we request information on both inclusions and exceptions for specific clinical situations (i.e., whether and to what extent a supply limit could be based on specific indications or other criteria) and other parameters and what safeguards should be in place to protect appropriate beneficiary access.	Aetna is supportive of 7 day supply for patients. We ask that CMS consider it only be applied to short-acting opioids as they are first line therapy for acute pain. We also recommend against the 50MME daily dose, alternatively Aetna suggest plans be encouraged to leverage quantity limits that CMS already reviews and approves today via the formulary submission process. Plans should be encouraged to monitor utilization and work with P&T Committee to decide whether or not to adjust the quantity limits
216	Improving Drug Utilization Review Controls in Medicare Part D	Concurrent Use of Opioids and Benzodiazepines	In 2016, the FDA added a boxed warning to prescription opioid analgesics, opioid-containing cough products, and benzodiazepines with information about the serious risks associated with using these medications concurrently. Sponsors can reduce the concurrent use of opioids and benzodiazepines, as well as other potentially problematic concurrent medication use at POS. Prospective drug use review can identify and evaluate the appropriateness of concurrent use prior to dispensing. CMS proposes that Part D sponsors implement a concurrent opioid and benzodiazepine soft POS safety edit. CMS is requesting feedback from stakeholders, especially Part D sponsors and PBMs, on their experience with concurrent or duplicative soft POS edits including an opioid and benzodiazepine and other drug combinations	Aetna recommends that this edit only fires when the prescribers are different and only fires when the opiate and the benzo exceeds a certain dose or days' supply. Plans should be encouraged to impose better formulary controls on Benzodiazepines
218	Using the Best Available Information when making B vs D Coverage Determinations for Immunosuppressant and Inhalation Durable Medical Equipment (DME) Supply Drugs		In order to streamline the coverage determination process and establish CMS as the single source for transplant information, CMS is proposing new guidance on how Part D sponsors should determine whether a drug is a Part B drug and when to revise its findings if the information from CMS changes. Though it is well established that Part D plans may not pay for drugs that would otherwise be paid under Part B, this proposal establishes CMS' expectations around how Part D plans perform due diligence to ensure that this does not occur. In all cases Part D sponsors should document the basis for their determinations to cover immunosuppressant and make such documentation available upon audit.	If this proposal is implemented, will CMS be writing detailed guidelines for plans to follow for implementation? (i.e. notification process, termination of authorizations, expectations of the plan for outreach to pharmacies on code submission for DME, expected updates to MARx). To ensure proper member outcomes, detailed CMS guidance will be required to ensure that system updates and process improvements meet the requirements of this proposed update. If a Part D sponsor determines during retrospective review that the information provided by the prescriber was inaccurate and that the member is not entitled to the medication under their Part D benefit, can the Part D sponsor leave claims incurred prior to this realization in a paid status and discontinue coverage of the medication going forward? Can CMS clarify what they mean by the statement 'no changes need to be made to prior Part D claims'. Does this mean leave them paid under Part D but reverse the PDE record or does it mean that we can leave the PDE record? Is CMS proposing to add transplant data to MARx for other organ transplants? CMS only provides MARx data for kidney transplants and dialysis services at this time.

Attachment A:

The Future of the Medicare Advantage Employer Group Waiver Plan Market

The Future of the Medicare Advantage Employer Group Waiver Plan Market

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The Future of the Medicare Advantage Employer Group Waiver Plan Market

Approach and Key Findings

To evaluate the trends and outlook for the Medicare Advantage Employer Group Waiver Plan (MA-EGWP) market, Aetna engaged Avalere, a public policy and business strategy consultancy in Washington, DC, to conduct a series of interviews.

In 2014, Avalere interviewed ten employers offering MA-EGWPs to retirees, including two unions, six public employers, and two private employers, totaling around 19% of national 2014 MA-EGWP enrollment (or approximately 554,000 individuals).

In 2015, Avalere conducted five interviews with key thought leaders, including high-ranking government officials and prominent scholars to discuss the future of the retiree market.

Most recently, in 2017, Avalere spoke with two benefits consultants at two different leading consulting firms who focus on MA-EGWP coverage.

Avalere shared an interview guide with all interviewees before conducting telephone interviews.

Key findings from the interviews include:

- Despite an overall decline in the number of employers that offer retiree healthcare, those that do offer coverage are intent on "keeping the promise" they made to employees.
- Employers are hesitant to disrupt their retirees' coverage by changing benefit designs, but rising costs are putting pressure on them to do so.
- Switching to MA-EGWPs has allowed many employers to maintain consistent coverage for retirees, while lowering their immediate costs and long-term liability.
- Additionally, the care management that MA-EGWPs provide can lead to better health outcomes and may contribute to the satisfaction with MA-EGWPs retirees report; in a recent survey, 92% of beneficiaries in MA report that they are satisfied with the quality of their coverage.[1]
- Preserving stable payment policy, allowing MA-EGWP plans more flexibility to tailor benefits, and expanding the information about MA-EGWPs available to employers can help the MA-EGWP market continue to grow and give employers a robust, sustainable option for continuing to provide coverage for retirees.

Background

Medicare-Eligible Retiree Health Coverage

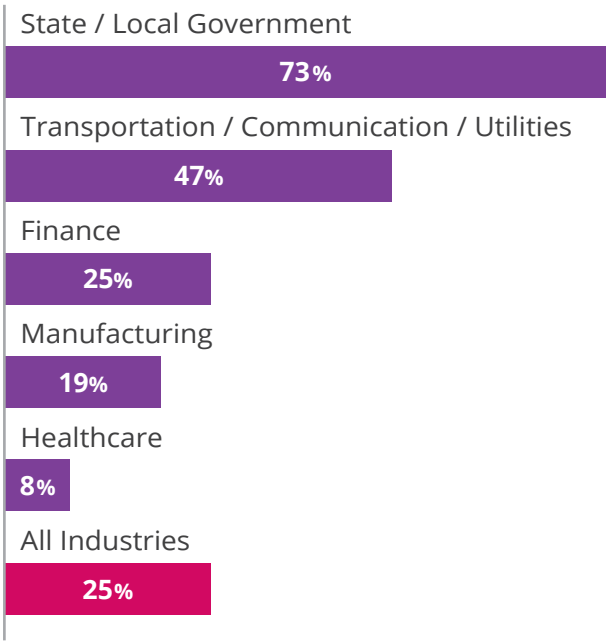
Over 17 million retirees rely on employer-sponsored coverage as a source for primary and supplemental benefits.[2] While many employers (i.e., private companies, public companies, and government institutions) continue to offer retiree coverage, cost concerns, the changing needs of the workforce, and new public policies have led to a decline in the number of employers that offer health benefits to their retirees over the last two decades. Voluntary employees beneficiary associations (VEBAs), which are trusts designed to finance benefits for retirees that worked for a particular employer or were part of a union, are also facing challenges with continuing to offer coverage.

For example, changes to accounting requirements may have been a disincentive for some employers to continue offering insurance. Statement 106 of the Financial Accounting Standard Board (FAS 106) required private sector employers to change their accounting practices regarding providing retiree health benefits and account for both current and future costs on their balance sheets.[3] Similarly, in 2004, the Governmental Accounting Standards Board's Statement 45 (GASB 45) required public employers (e.g., state and local governments) to do the same. These changes in accounting standards contributed to the cost pressures employers were experiencing, causing many that were not required to offer benefits by law or collective bargaining agreement to stop offering coverage. Among those employers that continued to provide health benefits to retirees, many considered offering fewer or less generous benefits.

Today, only 25% of employers with 200 or more employees offer health benefits for their retirees, a decrease from 40% in 1999 and 66% in 1988.[4] Notably, many organizations that continue to offer health insurance for existing retirees or current employees no longer offer coverage options for new employees. The percentage of employers offering retiree coverage differs by organization size and by industry, with public sector employers being the most likely overall to offer retiree health coverage.

Among Large Employers (200+ Employees) Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits by Industry, 2017[5]

Selected Industries:



The employers that continue to provide coverage are increasingly seeking innovative ways to manage costs while offering high-quality benefits to their retirees. In particular, state and local governments often face budget constraints and may, as one benefits consultant reported, struggle to balance providing health coverage for retirees with increasing salaries and benefits for current employees.

As multiple interviewees noted, employers in both the private and public sectors do not want to disrupt their retirees' coverage or be forced to structure benefits so that insurance becomes unaffordable. In this context, MA-EGWPs are proving to be an increasingly attractive option. MA-EGWPs help employers reduce the cost of providing coverage while maintaining consistent benefits for retirees.

"Certain employers have made a lifetime promise to their employees to offer retiree coverage, and the employers that could and wanted to eliminate retiree coverage have largely done so."

Overview of MA-EGWPs

The Medicare Modernization Act (MMA) of 2003 provided additional flexibilities for employers offering health benefits to their retirees by allowing the Centers for Medicare & Medicaid (CMS) to waive select MA program requirements to create a new type of MA plan, MA-EGWPs. Unlike other types of MA plans, MA-EGWPs can offer benefits only to the retirees of a particular employer or union and offer different premiums to beneficiaries living in different regions while providing the same benefit design nationwide.

Perspectives

Employer | "We evaluate offering retiree coverage every year, but haven't stopped yet – probably the reason why is because of MA-EGWPs."

Benefits Consultant | "Employers' ability to sustain their promise has been enhanced by EGWPs."

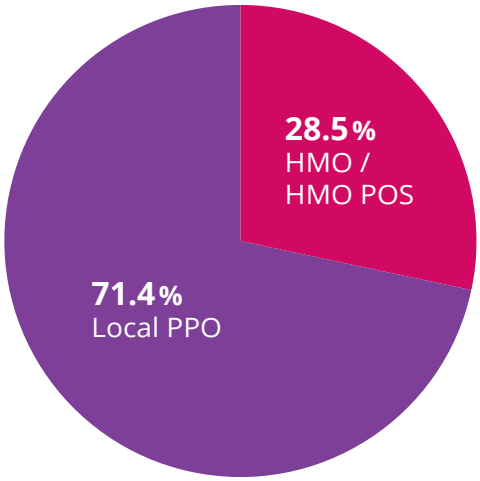
Under the MMA, employers also have flexibility in providing Medicare Part D prescription drug coverage. Employers can choose to receive a subsidy to provide drug coverage, offer retirees a Part D EGWP, offer separate MA medical and Part D EGWPs, or offer a plan that combines both Part D and MA medical coverage (called a Medicare Advantage – Prescription Drug or MA-PD EGWP).

Currently, just under 58% of MA-EGWP enrollees are enrolled in combined MA-PD plans, compared to nearly 100% of non-EGWP MA enrollees.[6] In some cases, employers choose to use the Retiree Drugs Subsidy (RDS) option or a separate EGWP Prescription Drug Plan (PDP) in combination with a separate MA-EGWP that provides only medical benefits, particularly if they provided separate medical and drug coverage prior to switching to MA-EGWP coverage.

Like other types of MA plans, MA-EGWPs can be either local or regional preferred provider organization (PPOs) or Health Maintenance Organizations (HMOs). However, the vast majority, approximately 71%, of MA-EGWPs are local PPOs.[7]

Employers interviewed noted that using extended service area PPOs allow them to provide coverage for retirees living in widespread geographies and to give retires access to in- and out-of-network providers at the same cost.

MA-EGWP Enrollment by Plan Type, 2017[8]



The following table shows how MA-EGWPs' unique waivers can be used to create a customized, flexible solution for plan sponsors who continue to offer retiree benefits.

Table 1: Waivers Available for MA-EGWPs

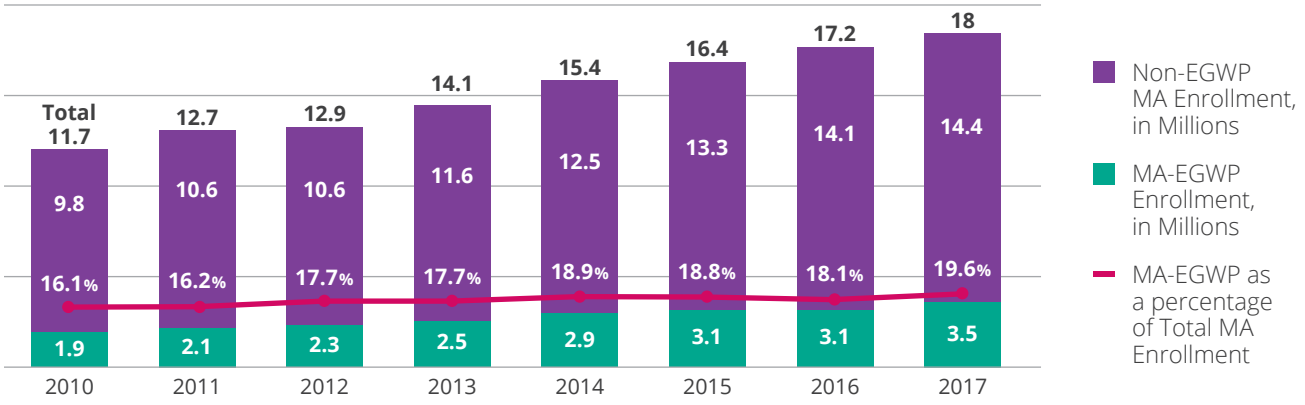
MA Requirements	MA-EGWP Waivers
Enrollment Requirements	Plan sponsors may customize the plan and offer only to the company's retirees. To better accommodate employers' retirees, MA-EGWPs: • May enroll Part B-only members • Do not have to comply with the Medicare annual coordinated election period • Can modify some of the required enrollment notifications • May waive certain minimum enrollment standards
Service Area Rules	MA-EGWPs are also allowed to tailor their offerings so that they serve retirees living in widespread areas: • In certain circumstances, CMS will waive the requirement that plans can cover only beneficiaries in the service areas in which they operate • EGWPs can offer plans even if individual plans are not offered in the same areas • Coverage can extend to all retirees, regardless of which MA or PDP regions in which they reside
Network Requirements	MA-EGWPs are established using a network of contracted providers, and can also be customized to have no differential between in- and out-of-network benefits. A CMS waiver allows for this customization when 51% (or more) of a group's members reside in a network service area. As a result, retirees are often able to see any provider who accepts Medicare payment and is willing to file the claim with a plan on behalf of the patient
Premium Requirements	MA-EGWPs are also permitted more flexibility to modify premiums to suit the needs of employers and retirees: • CMS will waive the uniform premium requirement meaning EGWPs can vary premium and cost sharing amounts for enrollees in different geographic areas • CMS will allow EGWPs to determine how much of the Part C and Part D premiums they will subsidize • EGWPs are not required to have beneficiaries use premium withholds
Marketing Rules	CMS will waive prior review and approval requirements for MA marketing materials and specific Part D marketing/ beneficiary communications
Bidding	MA-EGWPs do not submit bids to CMS and their offerings do not have to meet CMS' meaningful difference requirements

MA-EGWP Enrollment Trends

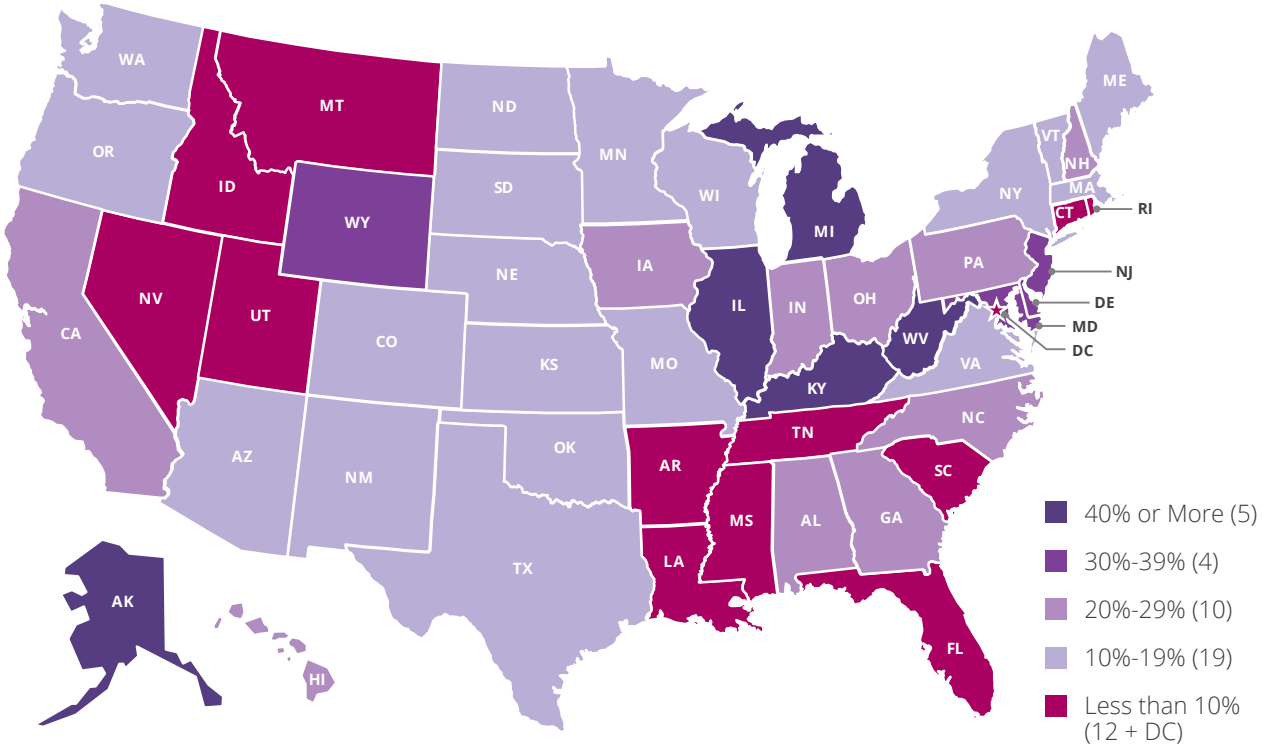
In 2017, over 3.4 million Medicare beneficiaries are enrolled in MA-EGWPs, comprising 19.6% of total MA enrollment.[9] MA enrollment has grown steadily from 11.7 million beneficiaries in 2010 to nearly 18 million in 2017.[10] Over that time, MA-EGWP enrollment has not just grown in numbers, but also as a percentage of total MA enrollment.

Notably, MA-EGWP enrollment varies as a percent of total MA enrollment by state, with higher concentrations in some counties and metropolitan areas than in others.

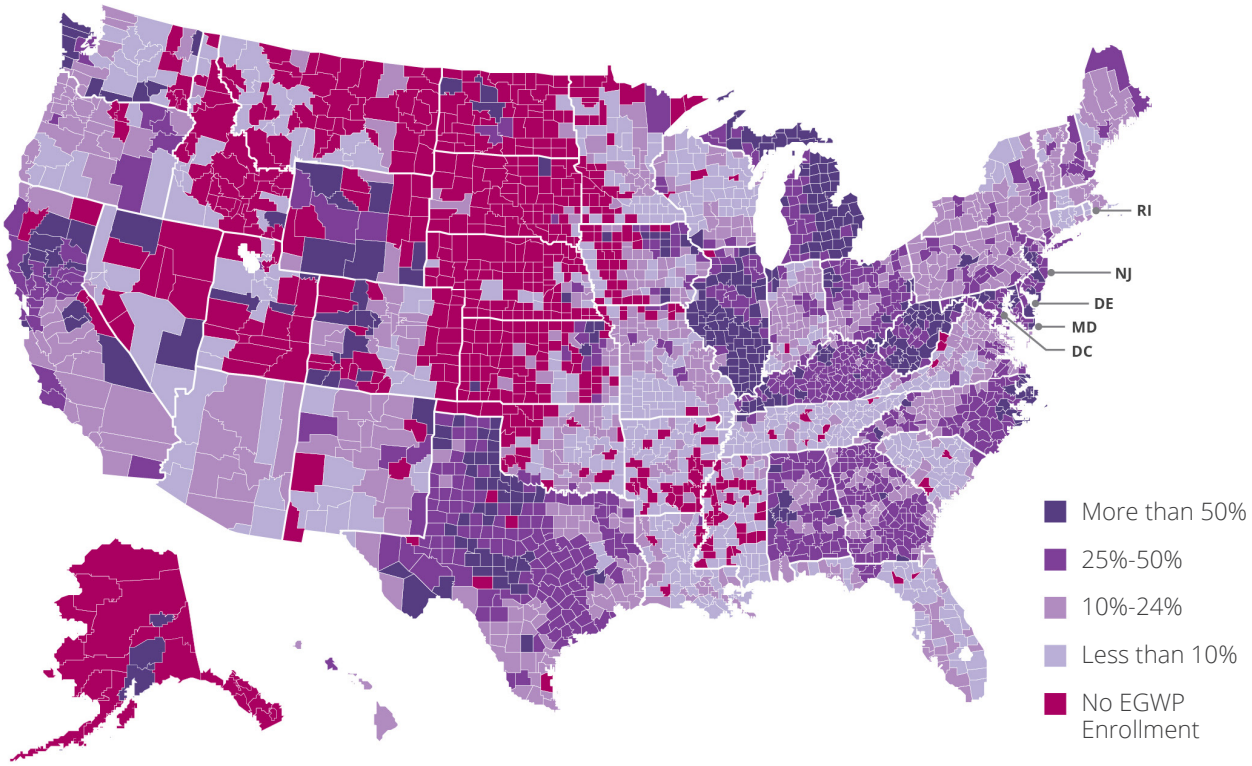
National Medicare Advantage Enrollment, 2010-2017, in Millions[11]



MA-EGWP Enrollment as a Percent of Total MA Enrollment by State, 2017[12]



MA-EGWP Enrollment as a Percent of Total MA Enrollment by County, 2017 [13]



MA-EGWP Payment

Each year, non-EGWP MA plans submit bids to CMS outlining their expected costs for providing coverage for the coming year. These plans are then paid by comparing these bids to county-level benchmarks set by CMS using data on fee-for-service Medicare costs. Plans with bids that are lower than the benchmark receive a portion of the difference to use to enhance their offerings to appeal to beneficiaries (e.g., by providing supplemental benefits like vision or dental), incentivizing plans to bid below benchmark. If plans bid above the benchmark, the difference between the bid and the FFS benchmark must be financed by premiums, making the plan a more expensive, less attractive option for beneficiaries.

Until recently MA-EGWPs, similar to other MA plans, submitted bids to CMS. However, in 2016, CMS proposed that MA-EGWPs no longer submit bids because it was concerned that MA-EGWP plans were not bidding far enough below the benchmarks. Instead, CMS proposed that payment for MA-EGWPs be based on bids from individual market MA plans.

In response to concerns about rapidly transitioning to this new methodology, CMS has, for 2017 and 2018, derived payment rates based on a blend of MA-EGWP and non-EGWP bids and used a 50-50 blend of individual MA and MA-EGWP bids. In the future, CMS may transition to using only non-EGWP bids to determine payment rates for MA-EGWPs, lowering payments to MA-EGWPs. As a result, MA-EGWPs may offer fewer supplemental benefits or provide less generous coverage.

Similar to non-EGWP MA plans, payment to MA-EGWPs is risk adjusted, which means that these plans receive payment partly based on the health status, age, and other characteristics of their enrollees. The population enrolled in an MA-EGWP may vary from year to year as the population mix changes. Risk adjustment ensures that, despite changes in the enrolled retiree population, MA-EGWPs both receive stable payments year over year and have sufficient resources to provide appropriate care for sicker beneficiaries.

Quality and Star Ratings

Unlike Medicare FFS and indemnity plans, MA-EGWPs are incentivized to provide high-quality care by the MA Star Ratings program. Under this program, MA plans that achieve high scores on measures for quality of care and beneficiary satisfaction can use their quality ratings in marketing materials. Five-star MA plans in particular have preferential enrollment rules allowing year-round membership expansion, and all high-quality MA plans that are rated four-stars or above receive bonus payments that are used to enhance benefits offered to retirees or to lower premiums. As one benefits consultant noted, employers often use Star Ratings to evaluate the quality of MA-EGWPs when selecting a plan for their retirees. In some cases, employers, through their contracts with MA-EGWPs, may require that these plans maintain a high star rating, ensuring quality care for retirees.

The Value of MA-EGWPs

The benefits consultants interviewed reported that most employers view transitioning to an MA-EGWP as a long-term solution. In their experience, few employers have transitioned to MA-EGWPs and then changed course.

Perspectives

Employer | "We've had high satisfaction (99%), and if MA-EGWPs were no longer offered there would be disruption."

Employers also described their intent to continue offering MA-EGWPs. While interviewees cited varied benefits to MA-EGWP coverage, themes emerged.

EGWPs give employers flexibility to maintain consistent retiree coverage at lower costs.

Overall healthcare costs are rising, jeopardizing employers' ability to continue to provide coverage and retirees' ability to afford care. At the same time, employers do not want to offer less generous coverage. MA-EGWPs permit employers and unions to continue to offer retiree health care coverage, help defray retirees' rising health care costs, and provide a cost-effective solution for employers and unions to continue to provide retiree health care coverage.

Perspectives

Employer | "From the company's perspective, it's all about price, saving money. Being able to provide the same level of benefit at a more affordable price is the sole reason we did it."

Employer | "We have been able to offer very consistent coverage each year. In fact, the EGWP coverage mirrored the existing coverage we had prior to the MA plan."

Employer | "Members receive reduced cost-sharing and enhanced benefits through the MA EGWP."

All employers interviewed were able to provide similar coverage through MA-EGWPs as they were through their previous offerings. Additionally, all mentioned that MA-EGWP coverage offered "extra" benefits in comparison to what they previously offered (e.g., dental and vision services similar to those offered in individual MA plans) and could offer consistent benefits from year to year.

The benefits consultants interviewed agreed that the ability to lower costs for employers was a primary incentive for their clients to switch to an MA-EGWP. Of the employers interviewed, three noted that they experienced significant and immediate financial returns as a result of using MA-EGWPs; one employer reported savings of $50 million during the first year it offered an MA-EGWP.

In line with these examples, one of the benefits consultants said that MA-EGWPs can extend the longevity of funds that, once exhausted, would result in the employer no longer being able to offer coverage. Further, some employers noted that retiree out-of-pocket costs were lower under MA-EGWPs than under their previous Medicare supplemental coverage.

The care management and additional benefits that EGWPs provide appeal to employers and retirees.

MA-EGWPs offer opportunities for care coordination that are not available through traditional Medicare. All employers interviewed noted the benefits of care coordination and disease management and cited both as features that attracted them to MA-EGWPs. The benefits consultants interviewed confirmed that, more broadly, coordinated care appeals to employers. Further, one benefits consultant said that a higher degree of coordination can also appeal to retirees, as it can make it easier to navigate the healthcare system. In general, multiple interviewees noted that well-coordinated care can lead to better health outcomes, a higher quality of care, lower overall costs, and higher retiree satisfaction. For example, one employer noted that its MA-EGWP plan offered more affordable benefits for older, sicker populations.

Perspectives

Benefits Consultant | "Group MA improves upon the indemnity plan because it introduces a basic level of care management. Plans help retirees use the system efficiently, see the right doctor, etc."

Employer | "Care coordination strategies are very important to us when choosing our retiree benefit options. We are committed to MA because we believe in care management and that it is the big distinction between MA and Fee-for-Service (FFS) to help manage future costs. Having care management and high quality is essential to making the retiree coverage work over the long term."

Employer | "We care about the health and well-being of our retirees. We believe they receive a lot better care and a lot more touch points from the MA-EGWP."

Employer | "MA-EGWPs offer additional benefits to members around care management and better coordinated care."

In addition, the benefits consultants noted that, because of the MA Stars program, which evaluates and rewards positive outcomes on a variety of metrics, there is a constant push for MA-EGWPs to provide a consistent quality of care and improve performance. For example, MA enrollees tend to have fewer avoidable hospitalizations than retirees in Medicare FFS[14] and a 13% to 20% lower rate of readmission within 30 days.[15] In addition, a recent study finds that beneficiaries enrolled in MA have lower use of acute and post-acute care, and higher rates of return to the community than beneficiaries in FFS.[16] MA beneficiaries are also approximately 20% more likely than those in FFS to have an annual preventive care visit.[17]

Policy Considerations for the Future of the Market

MA-EGWPs are an important tool for employers that are continuing to provide retiree coverage, including non-Medicare services such as dental and vision. Enrollment in MA-EGWPs has been steadily growing, and there are numerous employers that may still be considering MA-EGWPs as a solution for providing long-term coverage for retirees. However, as one benefits consultant noted, "real or perceived" instability in the market could make employers hesitant to consider MA-EGWPs. Policies that encourage stability and flexibility can bolster growth in the MA-EGWP market, while funding concerns and instability could ultimately decrease employer and retiree access to MA-EGWPs.

Policy Changes that Could Impede Access to MA-EGWPs

Concern about Future Payment Structure for MA-EGWPs

As stated above, nearly three-quarters of MA-EGWP plans are PPOs. However, the new funding methodology bases payment for MA-EGWPs on the overall payment rate for the individual market, which is predominately comprised of HMO plans.[18] In 2016, the last year that MA-EGWP plans bid, the bid-to-benchmark ratios for PPO plans in both the MA-EGWP and the individual MA market were six percentage points higher than the bid-to-benchmark ratios for HMO plans in the same market.

Further, according to a Milliman analysis, "the five-year average bid-to-benchmark ratio for individual PPO plans is roughly 8.7% higher than that of individual HMO plans."[19] Basing payment for the MA-EGWP market on payment for the HMO-dominated individual market when MA-EGWPs are predominantly PPO plans will likely result in insufficient payment for MA-EGWPs based on the coverage that they provide.

MA Enrollment-Weighted Bid to Benchmark Ratios, 2016[20]

Perspectives

Benefits Consultant | "Employers made a promise to offer PPO-style plans nationwide…the group solution needs to be different from the individual solution."

As a result, MA-EGWPs may have to offer less generous benefits to retirees. Basing the payment for MA-EGWPs on the appropriate set of plans, i.e., MA-EGWP PPOs on the individual market PPO bid-to-benchmark ratio and MA-EGWP HMOs on the individual market's HMO bid-to-benchmark ratio, would make payment more accurate, while continuing to address CMS' concern that MA-EGWPs do not have strong incentives to submit low bids.

Concern Over the Health Insurer Tax and Its Effect on MA-EGWP Premiums

The Affordable Care Act (ACA) created an annual tax on health insurers, including MA-EGWPs, which is calculated based on the insurer's premium revenue. The Consolidated Appropriations Act of 2016 suspended the tax for 2017, but it will return in 2018. If the tax goes back into effect, premiums will likely increase, resulting in higher costs per member per month.[21] Consequently, employers would ultimately need to either spend more or increase retiree out-of-pocket costs to keep providing the same level of benefits.

Perspectives

Benefits Consultant | "There is also concern about the health insurer fee – does that come back in 2018? Because that could be between $25 and $45 per member per month. It's not insignificant. It can materially weaken the value prop of a Medicare Advantage strategy. It speaks to the volatility."

The magnitude of the resulting financial losses for employers would likely not be enough to completely undermine the cost-effectiveness of MA-EGWPs in comparison to other types of plans, but it would decrease the savings to employers substantially and could, in some cases, deplete limited reserves designed to fund retiree coverage at a faster rate. Further, many retirees, who live on fixed incomes, could struggle to afford higher costs if employers are forced to shift costs in order to be able to continue offering coverage.

Concern about Volatility in Future Accounting Costs Due to Premium Changes and Tax Changes

As previously noted, the requirement that employers account for retiree healthcare on an accrual basis can make MA-EGWPs an appealing option for reducing costs and long-term liability. Some interviewees noted that switching to MA-EGWPs reduced their long-term liability; in particular, one reported reducing its 30-year liability by $1.3 billion. However, any changes in policy that result in changes in costs to employers have a magnified impact and can cause undesirable year-to-year changes in an employer's financial records. In this context, it is particularly important that policies that impact MA-EGWPs from a financial standpoint remain stable. Changes in policy that have a financial impact, like the return of the health insurance tax, can introduce year-to-year volatility into the market, which can make employers hesitant to switch to an MA-EGWP.

Concern about Risk Pool and Selection

If changes in the market ultimately lead to substantially higher out-of-pocket costs for beneficiaries enrolled in MA-EGWPs, some retirees, particularly healthier retirees, may decide to leave the plan and seek out less expensive coverage. For example, some beneficiaries could choose to enroll in Medicare FFS rather than remaining in an MA-EGWP plan, which could mean that the beneficiary could incur higher out-of-pocket costs, or need to purchase supplemental coverage, than if the beneficiary had remained an MA-EGWP.

Perspectives

Benefits Consultant | "The plan designs are attractive and keep the retiree population satisfied. Plans don't tend to lose people from the group so long as they stay affordable."

In addition, retirees with poorer health would be less likely to switch to a cheaper, less comprehensive plan. As a result, the MA-EGWP risk pool would be smaller and, if the remaining retirees are in worse health than those that left the MA-EGWP, higher cost. The resulting volatility would jeopardize employers' ability to continue to offer consistent benefits and could result in a "death spiral" for the MA-EGWP, driving more beneficiaries into FFS or other coverage options.

Concern over Network Access for Rural or Low-Income Areas

Currently, to establish an MA-EGWP, there must be a direct contracting network available to at least 51% of an employer group's retirees. In some geographic areas, particularly those with fewer providers, creating a network that meets CMS' adequacy requirements can be challenging. Further, today's retirees move throughout the country; a significant number of an employer's retirees may move away from the area where the organization is located. Consequently, some employers that would like to offer an MA-EGWP, particularly those that are mid-size, may not be able to meet the 51% requirement. Eliminating this requirement, creating an appeals process, or at least setting the threshold substantially below 51% could allow more employers to provide MA-EGWPs – plans that would offer higher-quality benefits and care coordination features – to their retirees.

Policy Changes that Can Increase Access to MA-EGWPs

Allow Occupational Trade Associations to Sponsor MA-EGWP Plans

Occupational trade associations often have members that are working or have worked for small organizations. Typically, smaller employers do not offer MA-EGWPs. If professional trade associations were explicitly permitted to offer an MA-EGWP to retired members, similar to the flexibility allowed union groups, beneficiaries may have more coverage options and could access higher quality care.

Extending MA-EGWP coverage to a larger population would allow for greater efficiency of care for beneficiaries who would otherwise be in fee-for-service Medicare.

Enable MA-EGWP Plans to Further Tailor their Offerings and Pursue Innovative Approaches

Guidance from Medicare that allows MA-EGWPs more flexibility to coordinate care can increase efficiency and improve outcomes. In particular, greater ability to develop programs that target retirees with certain chronic conditions could enable MA-EGWPs to further lower costs and better serve beneficiaries. In addition, MA-EGWPs and employers could partner more closely to target education to retirees about relevant benefits and how to manage their conditions.

Perspectives

Benefits Consultant | "Plans need flexibility in how to structure benefit design, and to do things more creatively through value-based design for populations."

Increase the Information Available to Employers and Retirees about the Value MA-EGWPs Provide

There are still many employers that currently provide indemnity plans for their retirees who could benefit from transitioning to an MA-EGWP. However, employers are sometimes resistant to change coverage plans because they are hesitant to risk disrupting care for their retirees.

In addition, some employers may seek more transparency about how MA-EGWPs operate (e.g., how their care coordination models work).

In particular, one benefits consultant reported that many employers do not understand how MA-EGWPs set premium rates or how they use subsidies from the government and, as a result, are concerned that they are at a disadvantage when working with an MA-EGWP. More outreach on the part of MA-EGWPs, consultants, and the government could help employers understand how MA-EGWPs operate, how they are funded, and how their care management efforts can improve beneficiary health while lowering costs.

Perspectives

Employer | "Whether we continue with MA-EGWPs in future years depends, but the plan is to continue to the extent that it remains economically prudent."

Conclusion

Retiree health coverage is an important component of the benefit packages that employers and unions offer their workers. Indeed, many beneficiaries depend on continued coverage through their former employers. Overall, the employers and unions, benefits consultants, and thought leaders interviewed agreed that MA-EGWPs allow employers to provide consistent, sustainable coverage for their retirees. MA-EGWPs are cost-effective for employers; in one instance, an employer interviewed reported that the savings generated by switching to an MA-EGWP allowed the employer to continue to offer retiree health benefits when it would no longer have been able to afford to otherwise.

Further, MA-EGWPs allow retirees to access additional benefits and receive high-quality, coordinated support to improve care and health outcomes. However, funding disparities for group plans, especially basing payment on individual HMO plans, along with other policy changes, could threaten the financial stability of the market and may result in less generous benefits for retirees and lower cost savings for employers. By contrast, policies that expand and/or stabilize the MA-EGWP offerings will allow more retirees to have access to MA-EGWP coverage and give MA-EGWPs more flexibility to innovate, ensuring that MA-EGWPs remain an attractive option for employers and retirees in the future.

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Attachment B:

Employer Group Waiver Plan Funding: Analyzing the Impact of Bid-to-Benchmark Ratios

Please reference the additional document included with our submission entitled “Milliman - EGWP Funding Study.”

Attachment C: Social Determinants of Health Codes

We recommend that CMS consider including certain ICD-10 Z codes, which are a subset of the Centers for Disease Control and Prevention (CDC) ICD-10-CM Official Guidelines for Coding and Reporting FY 2018, Chapter 21.[1] In particular, we ask CMS to consider the following codes and sub-codes, which provide more specific descriptions of issues:

Z55-Z65 – Persons with potential health hazards related to socioeconomic and psychosocial circumstances:

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z59 – Problems related to housing and economic circumstances
  - Z59.0 – Homelessness
  - Z59.1 – Inadequate housing
  - Z59.4 – Lack of adequate food and safe drinking water
  - Z59.5 – Extreme poverty
  - Z59.6 – Low income
  - Z59.7 – Insufficient social insurance and welfare support
- Z60 – Problems related to social environment
  - Z60.2 – Problems related to living alone
  - Z60.3 – Acculturation difficulty
  - Z60.5 – Target of (perceived) adverse discrimination and persecution
- Z62 – Problems related to upbringing
  - Z62.1 – Parental overprotection
- Z63 – Other problems related to primary support group, including family circumstances
  - Z63.1 – Problems in relationship with in-laws
- Z64 – Problems related to certain psychosocial circumstances
- Z65 – Problems related to other psychosocial circumstances

We also ask CMS to consider the ICD-10 Z codes for social determinants of health, which appear on the following page.

[1] Available at: https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf.

Revision Dates: 2/9/2018

Social Determinants of Health ICD-10 Code List

Beginning on March 1st, 2018, the following ICD-10 diagnosis codes will be defined as **Social Determinants of Health** codes.

Please note that Social Determinants of Health codes may be added to or updated on a quarterly basis. Providers should remain current in their thorough utilization of these codes.

ICD-Code	Description
Z550	Illiteracy and low-level literacy
Z551	Schooling unavailable and unattainable
Z552	Failed school examinations
Z553	Underachievement in school
Z554	Educational maladjustment and discord with teachers and classmates
Z558	Other problems related to education and literacy
Z559	Problems related to education and literacy, unspecified
Z560	Unemployment, unspecified
Z561	Change of job
Z562	Threat of job loss
Z563	Stressful work schedule
Z564	Discord with boss and workmates
Z565	Uncongenial work environment
Z566	Other physical and mental strain related to work
Z5681	Sexual harassment on the job
Z5682	Military deployment status
Z5689	Other problems related to employment
Z569	Unspecified problems related to employment
Z570	Occupational exposure to noise
Z571	Occupational exposure to radiation
Z572	Occupational exposure to dust
Z5731	Occupational exposure to environmental tobacco smoke
Z5739	Occupational exposure to other air contaminants
Z574	Occupational exposure to toxic agents in agriculture
Z575	Occupational exposure to toxic agents in other industries
Z576	Occupational exposure to extreme temperature
Z577	Occupational exposure to vibration
ICD-Code	**Description**
Z578	Occupational exposure to other risk factors
Z579	Occupational exposure to unspecified risk factor
Z590	Homelessness
Z591	Inadequate housing
Z592	Discord with neighbors, lodgers and landlord

Z593	Problems related to living in residential institution
Z594	Lack of adequate food and safe drinking water
Z595	Extreme poverty
Z596	Low income
Z597	Insufficient social insurance and welfare support
Z598	Other problems related to housing and economic circumstances
Z599	Problem related to housing and economic circumstances, unspecified
Z600	Problems of adjustment to life-cycle transitions
Z602	Problems related to living alone
Z603	Acculturation difficulty
Z604	Social exclusion and rejection
Z605	Target of (perceived) adverse discrimination and persecution
Z608	Other problems related to social environment
Z609	Problem related to social environment, unspecified
Z620	Inadequate parental supervision and control
Z621	Parental overprotection
Z6221	Child in welfare custody
Z6222	Institutional upbringing
Z6229	Other upbringing away from parents
Z623	Hostility towards and scapegoating of child
Z626	Inappropriate (excessive) parental pressure
Z62810	Personal history of physical and sexual abuse in childhood
Z62811	Personal history of psychological abuse in childhood
Z62812	Personal history of neglect in childhood
Z62819	Personal history of unspecified abuse in childhood
Z62820	Parent-biological child conflict
Z62821	Parent-adopted child conflict
Z62822	Parent-foster child conflict
Z62890	Parent-child estrangement NEC
Z62891	Sibling rivalry
Z62898	Other specified problems related to upbringing
Z629	Problem related to upbringing, unspecified
Z630	Problems in relationship with spouse or partner
Z631	Problems in relationship with in-laws
Z6331	Absence of family member due to military deployment
Z6332	Other absence of family member
Z634	Disappearance and death of family member
Z635	Disruption of family by separation and divorce
Z636	Dependent relative needing care at home
Z6371	Stress on family due to return of family member from military deployment
Z6372	Alcoholism and drug addiction in family
Z6379	Other stressful life events affecting family and household
Z638	Other specified problems related to primary support group
Z639	Problem related to primary support group, unspecified
Z640	Problems related to unwanted pregnancy

Z641	Problems related to multiparity
Z644	Discord with counselors
Z650	Conviction in civil and criminal proceedings without imprisonment
Z651	Imprisonment and other incarceration
ICD-Code	**Description**
Z652	Problems related to release from prison
Z653	Problems related to other legal circumstances
Z654	Victim of crime and terrorism
Z655	Exposure to disaster, war and other hostilities
Z658	Other specified problems related to psychosocial circumstances
Z659	Problem related to unspecified psychosocial circumstances
Z7141	Alcohol abuse counseling and surveillance of alcoholic
Z7142	Counseling for family member of alcoholic
Z7151	Drug abuse counseling and surveillance of drug abuser
Z7152	Counseling for family member of drug abuser
Z72810	Child and adolescent antisocial behavior
Z72811	Adult antisocial behavior
Z7289	Other problems related to lifestyle
Z729	Problem related to lifestyle, unspecified
Z730	Burn-out
Z731	Type A behavior pattern
Z732	Lack of relaxation and leisure
Z733	Stress, not elsewhere classified
Z734	Inadequate social skills, not elsewhere classified
Z7389	Other problems related to life management difficulty
Z739	Problem related to life management difficulty, unspecified