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January 15, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)

To Whom It May Concern:

I submit these comments on behalf of Mount Carmel Health Plan, Inc. (H3668) and Mount Carmel Health Insurance Company (H1846) (both d/b/a "MediGold"). MediGold is a provider-based, not-for-profit Medicare Advantage ("MA") plan. MediGold has been serving Ohio seniors and others who are eligible for Medicare since 1997.

MediGold appreciates that the Centers for Medicare & Medicaid Services ("CMS") continues to refine the Star Ratings program. In order to fulfill the program's goals, we believe that the Star Ratings must appropriately incentivize plans and accurately measure their performance. Accordingly, we urge CMS to (1) provide predictable and stable cut points for individual measures; and (2) finalize its proposed changes to the determination of Star Ratings and Quality Bonus Payments ("QBPs") for recently consolidated contracts. Finally, we encourage CMS to make these recommendations effective as soon as possible.

(1) Cut Points for Measure-Level Star Ratings (42 C.F.R. §§ 422.166(a), 423.186(a))

MediGold encourages CMS to establish pre-determined cut points for each Star Ratings measure or, at a minimum, return to the use of a pre-determined 4-star threshold.

CMS proposes to determine the cut points for individual Star Ratings measures using either clustering or a relative distribution and significant testing methodology. MediGold urges CMS to reconsider this proposal, as it creates uncertainty among plans and can unexpectedly penalize plans that have improved performance.

Under the proposal, CMS would determine final cut points after the performance year has concluded. Accordingly, plans would not have the opportunity to adjust priorities or improve performance to conform to shifting expectations. In some cases, plans that improve their

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performance year-over-year may actually be penalized. For example, MediGold improved its score on the Controlling Blood Pressure measure from 58% to 66% in one year; despite this improvement, MediGold's rating on the measure dropped from a 3-star to a 2-star. Notably, based on the preliminary cut points, MediGold expected the 66% score to garner a 4-star rating.

Penalizing plans that improve performance, especially when coupled with the uncertainty of unfixed cut points, undermines major goals of the Star Ratings program. In order to appropriately incentivize plans to improve performance, plans need predictable and stable goals. As the Medicare Payment Advisory Commission ("MedPAC") noted, "[f]ixed benchmarks provide a clear signal to plans about the level of performance necessary to achieve a given ranking, and they help plans target performance improvement efforts."[1] Further, unexpected swings in cut points can lead to lower QBPs and decreased revenue, potentially resulting in higher premiums and increased cost-sharing for beneficiaries. This is particularly true for smaller plans, where slighter changes in member and/or plan behavior can significantly affect performance scores.

We urge CMS to provide plans with predictability and stability in the determination of cut points and believe this can be achieved most simply through pre-determined, fixed cut points.

(2) Contract Consolidations (42 C.F.R. §§ 422.162(b)(3), 423.182(b)(3))

MediGold encourages CMS to finalize its proposal to calculate Star Ratings and QBPs for certain recently consolidated contracts based on an enrollment-weighted mean.

CMS proposes to change the way it calculates the Star Ratings and QBPs for contracts involved in consolidations of two or more contracts of the same plan type under the same parent organization. Generally, CMS proposes to calculate the Star Rating for the contracts for the first two years after consolidation based on an enrollment-weighted mean of the consumed and surviving contracts.

MediGold supports this proposal and urges CMS to finalize the change. The current method of determining Star Ratings for consolidated contracts (*i.e.*, applying the Star Rating of the surviving contract) allows MA Organizations to combine lower-performing contracts with higher-performing contracts such that the higher-performing contract's Star Rating survives. As MedPAC noted, such consolidations have allowed MA Organizations to shift enrollees to bonus-eligible plans.[2] We agree with CMS that this practice reduces the utility of the Star Ratings as a tool to signal quality and to reward high-performing plans. Moreover, we note that this policy disproportionately disadvantages smaller MA Organizations such as ours, who may only have one or two contracts and are thus unable to avail themselves of the opportunity to consolidate and the ability to "crosswalk" members to bonus-eligible plans. This distorts the market and leads to inequitable financial impacts through the application of the QBP.

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[1] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2016, 354, *available at* http://www.medpac.gov/docs/default-source/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf.

[2] *Id.* at 330 ("The smaller number of plans with ratings and the greater share of enrollees in bonus-eligible plans is partly due to contract consolidations whereby an organization combines multiple plans under one surviving plan.").

MediGold appreciates CMS's attention to these important Star Ratings issues and encourages CMS to act promptly to assure the Star Ratings are an accurate and fair reflection of quality, including for smaller plans.

We look forward to working with you on these key issues. I can be reached at (614) 546-3152 or michael.demand@mchs.com

Sincerely,

Michael J. Demand
President & CEO
MediGold