America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

Matthew Eyles
President and CEO

March 1, 2019

Demetrios Kouzoukas, Principal Deputy Administrator and Director, Center for Medicare
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A., Director, Parts C & D Actuarial Group, Office of the Actuary
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage (MA) CMS-HCC Risk Model; Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter

Dear Mr. Kouzoukas and Ms. Lazio:

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on Parts I and II of the Advance Notice for Calendar Year (CY) 2020 for Medicare Advantage and Part D and the CY 2020 draft Call Letter. AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation.

Medicare Advantage continues to deliver for millions of Americans. Almost 22 million seniors and people with disabilities – a third of those eligible for Medicare – have chosen to enroll in the Medicare Advantage program. Enrollment increased by nearly 10 percent in just the last 12 months alone and by more than 90 percent since 2010. In addition, more than 45 million seniors and individuals with disabilities are covered under Part D, with more than 19 million receiving their benefits through a Medicare Advantage plan and 25.5 million through a stand-alone Prescription Drug Plan.

Our members are committed to serving people who enroll in Medicare Advantage and Part D plans. These programs are essential to improving and maintaining the health and financial security of a growing number of Americans. Medicare Advantage plans lead the way in advancing innovative, patient-centered programs that improve care, reduce consumer costs, and address the needs of seniors and others who qualify for Medicare.

Now in its second decade of operations, the Part D program has become a keystone of America's health care system. The strong participation of plans in Part D means that seniors have many choices and the control to find a plan that is best for them. Part D plans have been a model of consumer choice and market competition that have improved access to prescription drugs and reduced out-of-pocket costs for tens of millions of enrollees.

We strongly agree with CMS' statement in the Advance Notice that these programs have demonstrated the value of private sector innovation and creativity. We also commend CMS for its ongoing commitment to "continuing to strengthen Medicare Advantage by promoting greater innovation, transparency, flexibility, and program simplification." In support, our comments highlight proposals in the Advance Notice and draft Call Letter that will promote these goals, such as provisions for new benefit flexibility for chronically ill enrollees, refinement of the Agency's adjustment in the Star Ratings program to account for socioeconomic status, and additional benefit flexibility for retiree plans.

However, AHIP and our member companies also have significant concerns with certain proposed changes that would undermine the program's ability to deliver affordability, stability, and choice for those eligible for Medicare. They include changes that would significantly reduce risk scores, particularly for low-income enrollees, and the absence of an adjustment in the county benchmark calculation recommended by the Medicare Payment Advisory Commission (MedPAC). We believe the adjustment is legally required under the Social Security Act. The net effect is that 2020 payment levels are estimated by CMS to be well below expected growth in medical costs. We also note that the health insurance tax will resume in 2020 unless Congress acts, putting additional pressures on premiums and available supplemental benefits. To ensure Medicare Advantage can continue to deliver value, we urge CMS to enhance its transparency and engage with stakeholders outside of the rate notice process in developing the risk model and in making other payment policy changes that have major implications for the benefit packages that Medicare Advantage plans can offer to enrollees.

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

We also believe it is critical to highlight that the Advance Notice and draft Call Letter process is transpiring while the Administration is simultaneously considering other major changes that could dramatically impact the Medicare Advantage and Part D programs in 2020. These proposals contain elements significantly affecting the costs and benefits available to Medicare Advantage and Part D enrollees, and several are unlikely to even be finalized prior to the June 3 bid deadline, which further increases uncertainty. The CMS proposals include a proposed rule to implement certain legislative changes and other proposed policies for Medicare Advantage and Part D; a separate Medicare Advantage/Part D proposed rule to lower drug prices and reduce out-of-pocket expenses; proposed amendments to the safe harbor rules relating to rebates under the Federal anti-kickback statute for Part D plans; and a proposed rule imposing new Medicare Advantage interoperability and patient access requirements. Moreover, while voluntary, we note the CMS Innovation Center also recently proposed a new model Part D payment model and an expanded Medicare Advantage value-based insurance design model for 2020.

It is essential for CMS to recognize that the totality and timing of these potential policy and operational changes contribute to an overall level of uncertainty for Medicare Advantage plans for 2020. Such uncertainty undermines an orderly bid development process and a predictable operating environment, which are critical to ensuring stability for Medicare Advantage and Part D enrollees and the ability of Medicare Advantage plans to make new and additional investments in

innovative programs and capabilities that will benefit enrollees. Various elements of these regulatory proposals also run counter to the Administration's commitment to reduce administrative burden. We urge CMS to take these considerations into account in both the Final Notice and Call Letter as well as in the processes affecting the other proposals.

The Value of Medicare Advantage

Medicare Advantage plans deliver better care and better value through innovative, patient-centered programs that improve quality and reduce beneficiary costs:

- **Greater care coordination and more comprehensive benefits.** Medicare Advantage plans work with their members to prevent, detect, and manage chronic conditions through programs that integrate and coordinate care. In addition, plans provide more comprehensive benefits than the traditional Medicare program – such as dental, hearing, and vision coverage – as well as offer more extensive telehealth services and new types of supplemental benefits that can also help to address various social determinants of health.
- **More financial security.** All Medicare Advantage plans cap enrollee annual out-of-pocket costs, and 90 percent of those eligible for Medicare have an option to enroll in a Medicare Advantage plan that offers drug coverage for no additional cost.
- **Better health outcomes.** Recent peer-reviewed research studies have found that Medicare Advantage plans have outperformed the traditional Medicare program on clinical quality measures[1], employed value-based payment arrangements to improve survival rates while lowering costs[2], reduced hospital readmissions as well as patient days spent in rehabilitation facilities and nursing homes[3,4], and lowered hospital use in the last days of life.[5]
- **Cost efficiency for consumers and taxpayers.** For many years, average plan bids for delivering the basic Medicare benefit have been well below Medicare fee-for-service (FFS) costs. Further, according to MedPAC average payments to Medicare Advantage plans in 2019 are equivalent to traditional Medicare costs.[6] And in areas of the country where Medicare Advantage is popular, additional enrollment leads to slower traditional Medicare

[1] Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.
[2] Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.
[3] Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoSMed* 15(6): e1002592.
[4] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.
[5] Teno, Joan M., Gozalo, Pedro, Trivedi, Amal N. et al. Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. *JAMA* Published online June 25, 2018.
[6] Medicare Payment Advisory Commission. Medicare Advantage program: Status report [presentation]. December 7, 2018.

spending growth as providers employ Medicare Advantage practice patterns and care guidelines for their remaining traditional Medicare patients.[7]

In addition, a recent survey finds continued high satisfaction with the Medicare Advantage program, with 90 percent of Medicare Advantage members reporting satisfaction with their health care coverage and preventive services, and 84 percent satisfied with their prescription drug coverage.[8]

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

- **Expanded Supplemental Benefits for the Chronically Ill.** AHIP commends CMS for indicating plans would have "broad discretion" in offering new supplemental benefits that have a reasonable expectation of improving or maintaining health or overall function of enrollees with chronic illnesses and would be able to vary those benefits for specific medical conditions and needs. However, we urge CMS to provide additional clarifying guidance and ensure flexibility, particularly related to permissible benefits, eligible chronic conditions, and marketing, as soon as possible.
- **Star Ratings Improvements.** The Star Ratings program is an important driver of quality improvement for Medicare Advantage and Part D enrollees. We support the continued use of the Categorical Adjustment Index (CAI) in the Star Ratings program while CMS develops a long-term solution to address the impact of socioeconomic status on quality measures. We also appreciate the changes CMS is proposing to the CAI, including expanding the number of measures used to calculate the CAI and allowing the CAI to reflect both within- and across-contract differences in performance based on socioeconomic status. However, we are recommending that CMS protect against potential negative impacts from this proposed change in 2020.
- **New Diagnosis Codes for Risk Adjustment.** We support the inclusion of dementia and pressure ulcer codes in an updated risk adjustment model CMS has proposed. However, as noted in our comments last year – and described below – we have concerns with the way CMS is proposing to update the model to reflect a beneficiary's specific number of conditions.
- **Employer Group Waiver Plans (EGWPs**). We commend CMS for a provision implemented for 2019 that uses a bid-to-benchmark calculation methodology that reflects the enhanced use of Preferred Provider Organizations in EGWPs and for continuing that approach moving forward. We also support CMS' proposed change for 2020 to restore the ability of EGWPs to use rebate dollars to reduce enrollees' Part B premiums.
- **Puerto Rico Relief.** We welcome the Agency's willingness to continue certain policies of importance to plans covering Medicare enrollees in Puerto Rico. While not specifically addressed, we recommend CMS clarify that it will continue to make adjustments in the Star Ratings program for Puerto Rico plans related to the calculation of the CAI and treatment of

[7] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.
[8] Morning Consult National Poll. November 28-29, 2018.

medication adherence measures. We also urge CMS to continue its adjustment to reflect the larger proportion of FFS Medicare beneficiaries in Puerto Rico who have zero claims compared to other parts of the United States. However, we are disappointed CMS has not implemented further adjustments in payments to address the significantly lower benchmark rates in Puerto Rico and urge the Agency to continue exploring that issue.

Key Policy Concerns
AHIP and our members have significant concerns with several policies, including:

- **Benchmark Calculation.** In connection with the 2018 and 2019 Advance Notices, AHIP recommended that CMS calculate benchmarks using only individuals enrolled in both Medicare Part A and Part B – and exclude individuals enrolled only in Part A. As reflected in the attached legal analysis by Epstein Becker & Green, P.C., CMS must exclude Part A-only enrollees from the calculation based on the requirements of the Social Security Act. In addition, since those enrolled only in Part A are ineligible to participate in Medicare Advantage plans, excluding them from the calculations is appropriate as an actuarial matter and would be consistent with a recent MedPAC recommendation. While CMS does not address the issue in the current Advance Notice, we urge CMS to adopt the change in the Final Notice or, at a minimum, to provide a detailed analysis and response to the legal and actuarial issues raised by AHIP and other commenters.
- **Normalization Factor.** A primary reason why payment levels under the Advance Notice on average will not keep pace with expected cost trend is a technical adjustment that would reduce 2019 risk scores by 3.08 percent through the FFS normalization process. AHIP is concerned that the increased normalization factor is larger than appropriate. This is due at least in part to the fact the model is estimated on ICD-9 codes; yet, CMS is calculating risk scores using ICD-10 codes. We urge CMS to include more data years in the normalization factor to minimize inappropriate reductions in payments.
- **Expanded Use of Encounter Data.** CMS proposes to increase the percentage of risk scores derived from diagnoses reported through the encounter data system from 25 percent in 2019 to 50 percent in 2019. The Advance Notice also suggests that the blend of diagnoses from encounter data will be increased pro rata over the next two years such that encounter data diagnoses would generate 100 percent of risk scores in 2022. AHIP continues to have very significant concerns about the expanded use of encounter data for payment purposes given the unresolved operational issues that prevent CMS from generating complete and accurate risk scores and CMS' open acknowledgement that expanding the use of encounter data will reduce payments.[9,10]
- **Risk Model Changes.** AHIP commissioned Wakely Consulting Group (Wakely) to analyze the impacts of changes CMS is proposing in the risk adjustment model based on the number of health conditions for a beneficiary. We have serious concerns that risk scores for many enrollees with multiple chronic conditions would decline, particularly those dually eligible

[9] Centers for Medicare & Medicaid Services. 2020 Medicare Advantage and Part D Advance Notice Part II and draft Call Letter [Fact Sheet]. January 30, 2019.
[10] Department of Health and Human Services. Putting America's health first: FY2019 President's Budget for HHS. Available at: https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

for Medicare and Medicaid, while risk scores for individuals with no health conditions would increase.[11] AHIP understands that CMS is required to begin phasing in a model that takes into account the number of conditions starting in 2020. At a minimum, we recommend that CMS include proposed diagnosis codes for pressure ulcers and dementia in such a model, as Wakely's estimates indicate the negative impacts relating to dually eligible individuals would be lessened. We also urge CMS to engage with stakeholders to consider ways to improve the model for future years.

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

By working together, we can ensure that Medicare Advantage continues to be a leader in delivering affordability, access, choice, control, and innovation. We look forward to providing any additional information you may need and to continuing to work together to improve the health and well-being of patients and consumers.

Sincerely,

Matthew Eyles
President and CEO

[11] Wakely Consulting Group, "2020 Medicare Advantage Rate Notice: Summary and Analysis." February 2019. Available at: https://www.ahip.org/wp-content/uploads/Wakely-2020-Medicare-Advantage-Adv-Notice-and-Risk-Model-Impact-Report-2.28.2019-1.pdf

AHIP Detailed Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage (MA) Risk Model & Advance Notice of Methodological Changes for CY 2020 for MA Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter

CY 2020 Medicare Advantage Risk Model

On December 20, 2018, CMS published Part I of the Advance Notice, which includes proposed changes to the Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) Risk Adjustment Model for 2020.

For 2020, CMS is proposing a Payment Condition Count (PCC) model that would:

- keep new HCCs added in 2019 for mental health, substance abuse, and stage 3 chronic kidney disease;
- add condition count variables that would increase the risk score if a person has at least four HCCs, in accordance with the requirements of the 21st Century Cures Act; and
- add three new HCCs for dementia and pressure ulcers under an alternative PCC model.

In 2019, CMS had proposed the PCC model with condition count variables. Commenters, including AHIP, expressed concern about the impact of this adjustment. AHIP's analysis showed that the proposed 2019 PCC model would have *increased* risk scores for relatively healthier individuals with no conditions. In addition, the new model reduced risk scores for MA enrollees who receive full Medicaid benefits (full duals) and had at least two HCCs.

In response to concerns about the impact of the condition count adjustment, CMS stated that it would delay implementing these changes and conduct additional analyses. CMS noted that the statute, as written, allowed the Agency to begin implementing these changes in 2020, rather than in 2019, with a three-year implementation period.

AHIP has significant concerns that in the 2020 Advance Notice, CMS is now proposing the same PCC model that it initially proposed in 2019. CMS is also considering an alternative PCC model with three additional HCCs for dementia and pressure ulcers. We continue to believe that the PCC model, as developed, creates an arbitrary threshold at four HCCs, increases payments for individuals with no diseases, and reduces risk scores for full duals. We are also very concerned that CMS has not provided sufficient detail about the analyses it conducted to identify the PCC model as the preferred approach for accounting for the number of conditions of an individual. Nor does CMS discuss alternative approaches for implementing condition count variables, even though in the 2019 Advance Notice CMS stated that it analyzed over 20 different models before selecting the PCC model. This absence of transparency makes it extremely difficult for stakeholders to analyze the Agency's proposed risk adjustment model and provide the most constructive comments possible on the optimal way to effectuate Congressional intent and improve the MA program. AHIP's analyses show that the PCC model, rather than increasing risk scores for clinically complex individuals, appears to have the opposite effect.

We discuss these concerns, along with recommendations on how we believe CMS can best meet the requirements of the statute while minimizing the negative impact of model changes, in more detail below.

Impact of PCC Model

In its analysis of the risk score impacts of the proposed 2020 PCC model as compared to the 2019 model, conducted using Medicare fee-for-service (FFS) claims and enrollment data, Wakely Consulting Group (Wakely) found an overall impact of 0.55 percent.[12] However, the analysis also raises a number of concerns with the PCC model. As shown in the table below:

- Across all model segments, the PCC model *increases* risk scores for relatively healthier individuals with no conditions and decreases risk scores for individuals who have between four and six conditions.
- The PCC model reduces risk scores for dual eligible enrollees with multiple conditions. The risk scores for full dual aged enrollees who have between three and eight conditions would decrease. Full dual disabled enrollee risk scores would also decrease if they have between two and seven HCCs. Additional decreases are seen in risk scores for partial dual enrollees with multiple chronic conditions as well. These negative impacts conflict with what CMS said it wanted to achieve when it introduced the 2017 model – to better account for the higher costs of dual eligible enrollees.

Change in Risk Score by HCC Count (PCC Model vs. 2019 Risk Model)

HCC Count	Comm Non Dual Aged	Comm Non Dual Disabled	Comm Full Dual Aged	Comm Full Dual Disabled	Comm Partial Dual Aged	Comm Partial Dual Disabled	Inst.
Overall	0.5%	0.7%	0.5%	0.7%	0.8%	0.8%	0.3%
0	1.7%	5.2%	1.7%	9.3%	2.1%	7.2%	2.4%
1	0.6%	1.0%	1.0%	2.2%	1.2%	1.8%	1.7%
2	-0.2%	-0.9%	0.4%	-1.2%	0.1%	-0.9%	0.9%
3	-1.0%	-2.3%	-0.2%	-3.2%	-0.7%	-2.9%	0.1%
4	-1.2%	-3.7%	-0.8%	-3.2%	-1.7%	-4.3%	-0.5%
5	-0.8%	-3.2%	-1.3%	-3.3%	-1.0%	-1.7%	-1.1%
6	-0.3%	-1.6%	-0.5%	-1.5%	-0.7%	-3.0%	-0.7%
7	0.1%	-0.2%	-0.6%	-0.6%	-1.6%	1.7%	0.2%
8	1.5%	2.8%	-0.2%	1.0%	0.8%	2.3%	0.4%
9	1.7%	1.8%	0.8%	1.8%	3.4%	2.8%	0.2%
10+	4.2%	5.7%	3.1%	5.5%	5.3%	5.5%	1.1%

[12] Wakely Consulting Group, "2020 Medicare Advantage Rate Notice: Summary and Analysis." February 2019. Available at: https://www.ahip.org/wp-content/uploads/Wakely-2020-Medicare-Advantage-Adv-Notice-and-Risk-Model-Impact-Report-2.28.2019-1.pdf.

Impact of Alternative PCC Model
Wakely also analyzed the alternative PCC model that CMS proposes for consideration. This model is the same as the PCC model, except that it would include two additional HCCs for dementia and one additional HCC for pressure ulcers.

Wakely found an overall impact of the alternative PCC model of 0.32 percent.[13] The impacts are somewhat similar to the PCC model, but differ in notable ways. As shown in the table below:

- Across five of the six community model segments, the alternative PCC model increases risk scores for relatively healthier individuals with no conditions and decreases risk scores for individuals who have three or four conditions.
- Unlike the PCC model, the alternative PCC model has mixed results on risk scores for dual eligible enrollees with multiple conditions. The risk scores for full dual aged enrollees who have between two and four or more than six conditions would increase. Full dual disabled enrollee risk scores would decrease if they have between two and seven HCCs. Additional decreases in risk scores are seen for partial dual enrollees with multiple chronic conditions as well.
- Risk scores would increase for all HCC counts for institutionalized individuals with multiple chronic conditions. In the PCC model, risk scores are reduced for institutionalized individuals with between four and six conditions.

Change in Risk Score by HCC Count
(Alternative PCC Model vs. 2019 Risk Model)

HCC Count	Comm Non Dual Aged	Comm Non Dual Disabled	Comm Full Dual Aged	Comm Full Dual Disabled	Comm Partial Dual Aged	Comm Partial Dual Disabled	Inst.
Overall	0.3%	0.7%	-0.2%	0.4%	0.8%	0.2%	0.6%
0	0.0%	5.0%	-2.4%	7.9%	0.2%	7.0%	0.8%
1	0.4%	0.7%	-0.1%	1.6%	0.6%	1.6%	0.1%
2	0.0%	-1.0%	0.9%	-1.0%	0.0%	-1.0%	0.2%
3	-0.5%	-2.4%	0.7%	-2.7%	-0.4%	-2.9%	0.3%
4	-0.7%	-3.6%	0.1%	-4.1%	-1.5%	-4.2%	0.4%
5	0.1%	-2.9%	-0.4%	-3.3%	-0.7%	-1.8%	0.5%
6	0.4%	-1.1%	0.4%	-1.2%	0.1%	-2.2%	0.5%
7	1.0%	-0.7%	0.3%	-0.4%	-0.6%	1.3%	0.7%
8	2.4%	3.6%	0.4%	1.4%	-0.6%	3.2%	0.7%
9	2.5%	2.1%	1.2%	2.0%	5.3%	2.4%	0.9%
10+	4.9%	5.8%	3.1%	5.5%	5.9%	5.5%	1.3%

[13]Ibid.

Based on the results of these impact analyses, AHIP believes that the alternative PCC model is preferred to the PCC model. We also have previously supported inclusion of dementia in the risk model. However, we are concerned that Wakely found negative impacts in both models for many individuals with multiple chronic conditions. While the negative impacts for both aged and disabled full dual eligible enrollees in the PCC model are especially concerning, the alternative PCC model also shows negative impacts for many full duals who are disabled. In general, negative risk score impacts for individuals with multiple chronic conditions are inconsistent with the intent of 21st Century Cures Act to increase payments for sicker individuals. The decreases in the risk scores for many individuals with more than four chronic conditions is particularly concerning, especially since the add-on for the risk score begins with four HCCs for most model segments. If Congress' intent was for CMS to implement a risk model that increases payments for individuals with multiple chronic conditions, then CMS' approach does not appear to be achieving that goal.

Transparency
In Part I of the 2020 Advance Notice, CMS specifically acknowledges stakeholders' concerns about the impact of the PCC model:

> *"Some stakeholders submitted comments on Part I of the 2019 Advance Notice stating that the proposed PCC model did not meet the implied intent of the requirements in the 21st Century Cures Act to improve prediction in the CMS-HCC model for high need beneficiaries with multiple chronic conditions."*

However, we believe CMS has not directly responded to those concerns. As noted above, CMS did not present alternatives for stakeholders to review for 2020, even though the Agency stated in Part I of the 2019 Advance Notice that it considered **over 20 models** to account for the number of conditions of an individual. These alternatives included models that varied in terms of:

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

In our comments in response to the 2019 Advance Notice, AHIP specifically requested that CMS share with stakeholders the alternatives that were considered and their impacts. We also asked CMS to describe why the Agency believes the PCC is a better approach than any of these alternatives. Unfortunately, the Agency has not shared this information.

The only data or analyses CMS has provided came in a webinar[14] held in the fall of 2018, in which CMS presented a series of slides that showed predictive ratios (which are the predicted costs divided

[14] Slides from the webinar are at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/102618_CMS_RAModelResearchFindings_5CR_102518.pdf

by the actual costs) under these alternatives, but without a clear discussion of how stakeholders should interpret these predictive ratios. The predictive ratios do not provide a clear indication of the impact of the model on risk scores by disease or number of chronic conditions. As we have shown above, both the PCC model and the alternative PCC model would often result in reductions in risk scores for individuals with multiple chronic conditions. In the webinar, CMS also did not explain why it prefers the PCC model to other alternatives or provide information on the impact on MA risk scores under these alternative models. In summary, the webinar lacked sufficient information for stakeholders to assess the PCC model compared to other potential alternatives.

AHIP recognizes that since CMS has not proposed any alternative specifications to count the number of diseases, CMS will likely implement the PCC or alternative PCC model proposed in the 2020 Advance Notice in order meet the statutory requirement of the 21st Century Cures Act. We would recommend that CMS implement the alternative PCC model, as discussed above. However, we also note that the statute does not specify that CMS must use the same approach to account for the number of diseases in each year. That is, CMS can still explore and consider alternatives in future years to meet the requirement of the statute.

We recommend that CMS establish a Technical Expert Panel (TEP) for risk adjustment. This TEP would be an excellent approach for considering changes to the PCC or alternative PCC that appropriately adjusts payment for high acuity patients while not causing unintended or counterintuitive impacts on payment. AHIP and its members would welcome the opportunity to participate on such a TEP.

More broadly, in our previous comments, AHIP has urged CMS to enhance its transparency and engage with stakeholders outside of the rate notice process in developing the risk model. We continue to ask for this engagement. We also note that these views on transparency and collaboration were echoed by experts representing a wide range of stakeholders at a recent one-day symposium hosted by the American Action Forum and the Urban Institute. These stakeholders included representatives from the health insurance and pharmaceutical industries, academics, actuaries, consultants, and former CMS officials. While the symposium focused on calibration of a risk adjustment model using MA encounter data, the key recommendation generated through the symposium is applicable to the overarching process for development and maintenance of the risk adjustment model:

> *"The primary consensus recommendation that emerged from the summit focused on transparency. Experts said that CMS should provide more data on the current risk adjustment system and approach recalibration of the risk adjustment model with MA encounter data in a deliberative, open way that allows for stakeholder input and clearly lays out policy goals, potential effects on payment, and alternatives considered."*[15]

[15] Skopec, L., Garrett, B., Zuckerman, S, Holtz-Eakin, D., Holt, C., O'Neill Hayes, T. "Using Encounter Data in Medicare Advantage Risk Adjustment." Available at https://www.urban.org/events/using-encounter-data-medicare-advantage-risk-adjustment. American Action Forum and Urban Institute, January 2019.

We urge CMS to consider taking a more collaborative approach to the risk adjustment model and look forward to working with the Agency to improve the MA program.

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

As we note elsewhere in our comments, we have significant concerns about the increased use of encounter data for payment. We are also concerned that the blend proposed by CMS is inconsistent with how CMS has previously transitioned to a new risk model via a blend approach.
AHIP recommends that CMS adopt a methodology that includes a blend of the RAPS and EDS data within each model, before blending the risk score. This approach would ensure that the RAPS and EDS data are properly accounted for in each model.

Other Provisions in CY 2020 Advance Notice

Attachment II. Changes in the Part C Payment Methodology for CY 2020

Section B. Calculation of Fee-for-Service Cost

Puerto Rico (pp. 20-21). The MA program is critically important in Puerto Rico. The vast majority of Medicare beneficiaries in Puerto Rico are enrolled in MA plans (71 percent, as of February 2019). Many of these beneficiaries have low incomes and enroll in plans to receive more care coordination and affordable Part D coverage, which otherwise may not be affordable due to the statutory prohibition on providing Part D low-income subsidies (LIS) to beneficiaries in the territories.

We continue to be concerned about the large disparity in payment rates between Puerto Rico and the mainland. The unusually low FFS expenditures for Puerto Rico, which now serve as the basis for MA benchmarks, and the significant rate cuts for Puerto Rico put into place by the Affordable Care Act (ACA), jeopardize the continued availability of the comprehensive coverage provided by MA plans operating on the Island to the low-income populations they serve.

Given the unique circumstances of plans in Puerto Rico, we believe that CMS should explore all potential options for increasing MA benchmark rates for Puerto Rico to achieve greater parity with FFS rates on the mainland. Such an adjustment is needed to ensure that plans in Puerto Rico can maintain benefits for the low-income populations they serve.

The Secretary has previously directed the Office of the Actuary (OACT) to account for the fact that a higher proportion of beneficiaries in Puerto Rico than beneficiaries outside of Puerto Rico did not have any claims. As CMS noted in the 2020 Advance Notice, the Agency determined that 14.5 percent of Puerto Rico beneficiaries enrolled in both Medicare Parts A and B had no claims, as compared to 6.0 percent of beneficiaries nationwide during the period 2012-2016.

OACT applied this adjustment in the 2019 rates, and OACT is considering whether to make this adjustment for the 2020 rates.

We believe that the adjustment for zero claims remains necessary to ensure beneficiaries maintain access to the MA benefits they need, given the unique characteristics of Puerto Rico. We strongly encourage the Agency to continue making this adjustment if CMS does not make a broader adjustment to reflect low benchmarks as we have suggested above.

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

In addition, in the CY 2018 Final Notice CMS expanded the criteria used to determine which counties qualify for a double quality bonus payment to include certain counties in Puerto Rico. We support CMS in continuing to include these counties in Puerto Rico when determining which counties qualify for the double bonus payment in CY 2020.

Average Geographic Adjustment (AGA) Methodology for 2020 (pp. 15-22). CMS proposes several changes to the calculation of the AGAs used to determine the county benchmarks. These changes are primarily associated with the shared savings and losses of accountable care organizations, along with several demonstration programs. While AHIP supports the need for accuracy in the payment rates, we are concerned that we cannot assess the impacts of the changes being proposed.

In addition, with increased enrollment in alternative payment models (APMs), the methodologies used by CMS to account for APMs in the MA rates could adversely affect payments to MA plans if not done properly. For example, in 2020 providers participating in Advanced APMs can receive a 5 percent bonus payment. CMS does not mention in the Advance Notice how the Agency will account for these bonus payments in the 2020 county benchmarks or how payments from the Merit-based Incentive Payment System (MIPS) would impact the 2020 county benchmarks. In the Final Notice we would ask that CMS address how it is accounting for MIPS and APM adjustments in the county benchmarks.

We would also like to highlight a concern associated with how CMS adjusts payments to account for changes in Medicare Disproportionate Share Hospital (DSH) payments and uncompensated care payments (UCP). CMS proposes to adjust claims for fiscal year (FY) 2013 through first quarter FY2018 to reflect the requirements of the final FY 2019 Inpatient Prospective Payment System (IPPS) rule. UCPs are calculated as a product of three factors, one of which (Factor 3) includes the hospital's amount of uncompensated care relative to the amount of uncompensated care for all DSH hospitals.

Beginning in FY 2018, CMS implemented a three-year transition period that would phase out the use of proxy low-income days in calculating Factor 3 and completely shift to using uncompensated care data from Medicare Cost Report Worksheet S-10. Due to this three-year phase-in, Factor 3 will be

calculated differently in FY 2019 and FY 2020. As such, basing the 2020 AGA on the FY 2019 UCP calculation causes a lag, meaning that the AGA will not reflect the appropriate costs for 2020.

As a result, CMS should consider modifying the AGA calculation for payment year 2020 to reflect how UCPs will be calculated for FY 2020. More specifically, given that the Factor 3 used to calculate FY 2020 DSH payment adjustments will be based solely on Worksheet S-10 datasets, the historical claims data that is used to determine the AGA should also be adjusted to solely reflect Worksheet S-10 data. This change will ensure that the geographic redistribution associated with this FFS policy change is reflected in the benchmark and ensure that 2020 MA rates align with expected DSH payment adjustments in 2020.

We would also like to call attention to an inconsistency in CMS methodology for standardizing the county benchmarks. On page 19, CMS notes that it will standardize the county benchmarks using "the county's average five-year risk score from the 2020 risk model." Using only the 2020 risk model to standardize the rates is inconsistent with how CMS has proposed phasing in the new model. The standardization of the benchmarks must be conducted using the same blend of the risk model scores that CMS is using for payment. That is, CMS should standardize the rates using a risk score with a 50/50 blend of the 2020 PCC model and the 2017 model, consistent with how it will calculate risk scores for payment. We ask that CMS clarify how it intends to standardize the benchmarks in the Final Notice.

Calculating FFS Costs Using Enrollees Enrolled in Medicare Part A and Part B
We continue to believe that the methodology that CMS uses to calculate the benchmarks is inappropriate, both from a statutory and actuarial standpoint. To enroll in a MA plan, an enrollee must have Part A and B, yet CMS calculates the rate based on enrollees with Part A or B. We urge CMS to calculate benchmarks using claims experience for only those individuals with Part A and B.

As noted below, we believe that the Social Security Act requires that the Agency exclude Part A-only enrollees from the calculation of county benchmarks. In addition, actuarial principles require that an estimate of the benchmark must represent what that enrollee would cost in traditional Medicare. Given the construction of the statute, and that individuals with Part A and B, on average, cost more than individuals with Part A or B, we believe that CMS must make this change.

2018 and 2019 Rate Notices

CMS has previously acknowledged that a "large number of commenters" have requested that CMS change how it calculates benchmarks to address this issue. These comments included specific justifications for the change.[16] In the 2018 Final Rate Notice, CMS stated that "We appreciate the feedback submitted by commenters regarding this issue. We will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years."

[16] See the 2018 Final Rate Notice (pp 26-27).

In our comments to the 2019 Rate Notice, AHIP included a legal analysis from Epstein Becker & Green, P.C., which demonstrates that under a plain reading of the Social Security Act, including provisions in section 1876(a)(4), CMS should calculate benchmarks using claims experience only for individuals with Medicare Parts A and B. We also highlighted MedPAC's recommendation that the rates should be calculated based solely on enrollees with coverage under both Medicare Parts A and B, given the requirement that MA enrollees have both Parts and the fact that Part A-only enrollees have different health and utilization patterns.[17] AHIP recommended that, to ensure an accurate determination of FFS costs, expenditures for beneficiaries enrolled only in Part A should not be included in the calculation of the county benchmarks.[18]

In the 2019 Final Rate Notice (pp 22-23), CMS once again recognized that a "large number of commenters" had put forward policy arguments that changing the benchmark calculation "would be a more accurate, reasonable, appropriate, and/or equitable methodology;" and that MedPAC recommended the change. CMS also summarized the legal analysis put forward by AHIP. CMS responded to the comments with the following:

"Response: We appreciate the feedback submitted by commenters regarding this issue. While most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt-in to Part B coverage. As a result, we believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based only on the Medicare costs for beneficiaries who are enrolled in both Part A and Part B. With regard to the legal argument that CMS must develop the estimates of the USPCC using only data from beneficiaries who are enrolled in both Parts A and B of Medicare, we disagree with the commenter's interpretation of the statute and of the limits of our authority and discretion under the statute. We will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years for areas outside of Puerto Rico."

Despite the substantial amount of discussion and comment on the calculation of benchmarks using only enrollees in Medicare Parts A and B over the course of two rate notices, and Agency promises to continue analyzing this issue, the 2020 Advance Notice is entirely silent on this topic.

Legal Requirement

As indicated in the analysis from Epstein Becker & Green, P.C, we believe the statute compels the exclusion of Part A enrollees from the calculation of the county benchmark. We are re-submitting the analysis as an attachment for your consideration. We strongly urge CMS to adopt the straightforward

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

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

rationale reflected therein. However, if CMS continues to disagree, we believe the Agency must provide the numerous stakeholders raising this issue with an alternative analysis of the statutory language and construction that demonstrates CMS has clear authority to include Part A-only enrollees in the calculation and is not acting in an arbitrary manner. We would be happy to provide the Agency with any additional information that would be helpful in such an analysis.

Actuarial Issues

The current statutory structure for calculating county benchmarks is based on what Medicare would have spent on an individual enrolled in traditional Medicare. CMS' current methodology is to calculate separate Part A and Part B per capita rates, and then to add them together to arrive at an overall payment rate. This approach is used both for the national United States Per Capita Cost (USPCC) estimate, as well as the inputs used to determine the AGA for each county. The county benchmark is based on the product of the USPCC and the AGA, where the AGA is standardized by the average risk score for the county.

From an actuarial perspective, CMS' methodology is valid only if the rate obtained by summing the Part A and B rates is the same as the rate calculated using individuals with both Part A and B. However, CMS' own data clearly demonstrates that these rates are not, in fact, equivalent.

AHIP conducted an analysis of claim costs for enrollees with Parts A and B, vs. those with both Parts A and B. CMS publishes a file that includes claims for individuals with Parts A and B.[19] AHIP compared these costs with the ratebook files used by CMS to calculate the MA benchmarks for 2019.[20] The differences in these costs are material. As shown in the table below, the average per capita costs for someone with Part A and B are 4 to 5 percent higher than the average per capita costs for someone with Part A or B. Moreover, AHIP has estimated that this difference can be much larger in certain counties. Using these files, AHIP estimated that the payment rate for Los Angeles would be 12 percent higher, and the payment rate for Harris, Texas, which includes the Houston metropolitan area, would be 10 percent higher. Again, because the differences in these costs are material, AHIP believes that actuarial principles require that CMS calculate the benchmarks by excluding Part A-only enrollees from the calculation.

[19]AHIP used the CMS file named "State_County_All_Table 2012 to 2016.xls" for the A and B spending. This file has claim costs for enrollees with Part A and B. AHIP excluded hospice and dialysis costs. The file is located at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html

[20]AHIP used the CMS file named "Medicare FFS County 2019 Web.xlsm" for the A or B spending. This file has the costs for 2012 to 2016 by county. The file is located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/ffs2016.zip.

Differences in per capita spending for U.S., Part A or B vs. Parts A&B

Year	Per Capita Spending for U.S. – Parts A and B Coverage	Per Capita Spending for U.S. – Part A or B Coverage	Percent Difference
2012	$762.02	$728.44	5%
2013	$761.25	$723.36	5%
2014	$768.96	$734.11	5%
2015	$785.24	$754.79	4%
2016	$791.31	$763.53	4%

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

Payment Methodology for EGWPs (pp. 24-28). CMS is proposing to continue with the payment methodology that was introduced in 2017. Under this approach, EGWP payments for 2020 would be solely based on non-EGWP bid-to-benchmark ratios. CMS also proposes to continue using an adjustment made in 2019 that accounts for the fact that EGWP enrollees tend to be disproportionately enrolled in Preferred Provider Organizations compared to Health Maintenance Organizations. AHIP supports the continued use of this adjustment to ensure the payment ratios more accurately reflect expected costs.

AHIP also supports CMS' proposal to reinstate the ability of EGWPs to buy down beneficiary Part B premiums, which is permissible for individual market plans. This practice was previously allowed for EGWPs but has been prohibited since the new payment methodology was introduced in 2017. Reinstating this flexibility for EGWPs will allow these plans to provide lower costs for their members and promote competition with individual market plans on a more even playing field.

Section G. CMS-HCC Risk Adjustment Model for CY 2020 (p. 28)

Please see our earlier comments on the new risk model.

Section H. End State Renal Disease (ESRD) Risk Adjustment Model for CY 2020 (pp. 29-32)

CMS has proposed recalibrating the ESRD model using 2014 diagnoses to predict 2015 claims with some adjustments to account for underpredictions for functioning graft new enrollees and the long-term institutionalized (LTI) populations. CMS will also use the encounter data filtering logic for the encounter data portion of the risk score and will use the 2019 ESRD model for the RAPS based risk score. CMS proposes to blend the risk scores at 50/50 (50 percent encounter data and 50 percent RAPS). Given the concerns outlined below about encounter data, we would ask that CMS maintain the same 25 percent blend for encounter data-based risk scores for ESRD enrollees, and blend encounter data and RAPS-based risk scores within each model consistent with our recommendation on the 2020 PCC model.

Finally, we note that CMS has published a review of the ESRD model. This review largely found that the ESRD model predicts costs accurately for certain populations. We are concerned that this analysis, because it is based on the distribution of predicted, and not actual, costs, may not capture how well the model predicts actual costs. With ESRD enrollees able to enroll in MA plans beginning in 2021, we are concerned that the model may not adequately predict relative costs for this population. In addition, we have serious concerns that the underlying ESRD benchmark rates are not adequate to cover the costs of this population[21] and could lead to disruption in the market in 2021 when MA enrollment is expanded for this population. We request that CMS continue to engage with stakeholders on ways to improve the adequacy of the ESRD payment.

Section K. Medicare Advantage Coding Pattern Adjustment (p. 36)

The Advance Notice announces that for CY 2019, CMS is proposing to apply the statutory minimum MA coding adjustment factor of 5.90 percent. AHIP supports the Agency's decision to maintain and not exceed the statutory minimum adjustment level.

Section L. Normalization Factors

CMS-HCC Model Normalization Factor (pp. 36-39). CMS proposes a normalization factor of 1.075 for the 2017 CMS-HCC model, and 1.069 for the PCC model, which would result in a 3.08 percent reduction to MA plan payments from 2019. CMS proposes to use risk score data from 2014 to 2018 to estimate the normalization factor.

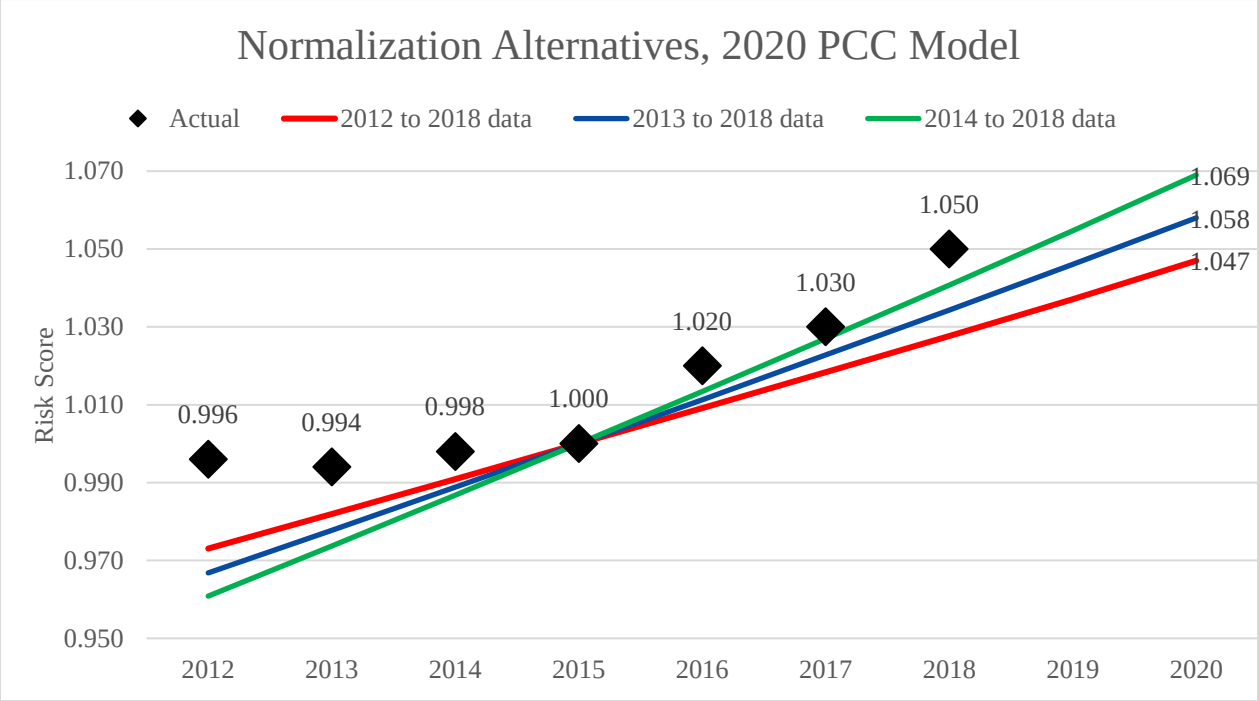
CMS notes large increases in the average FFS risk score for 2016, 2017, and 2018. This change occurred following the introduction of ICD-10 codes on October 1, 2015. The ICD-10 code set is much larger than the ICD-9 code set. CMS has not indicated it has analyzed what the trends in risk scores would be when using ICD-10 codes for model calibration vs. ICD-9 codes. If the ICD-10 switchover accounts for the increase, it would suggest that the normalization factors calculated by CMS are more of an artifact of the difference between ICD-10 and ICD-9 mapping to the HCCs, and coding differences in ICD-10 vs. ICD-9, than a real indication of higher risk scores in FFS Medicare.

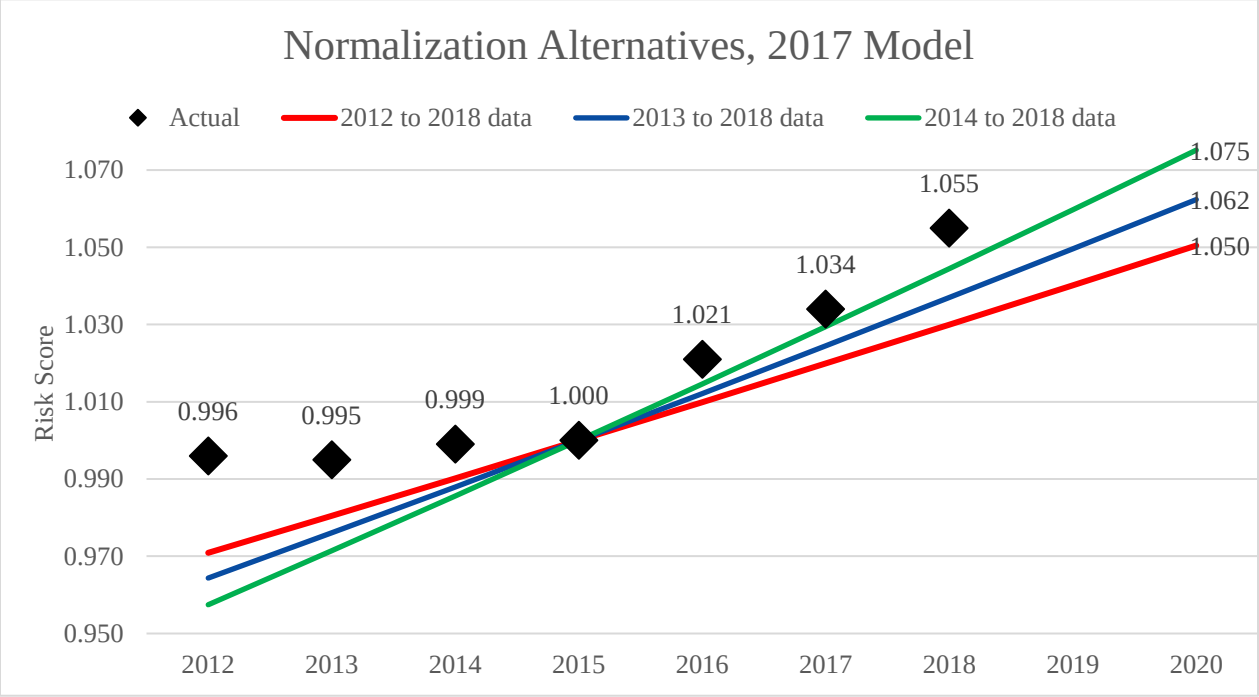
In addition, both the 2017 model and the PCC model are estimated on ICD-9 data, yet the 2016, 2017, and 2018 risk scores use ICD-10 data. This discrepancy between model estimation and model payment could be a likely cause of this increase, as compared to increases in risk scores due to changes in coding practices. We also note that the long period between calibration and payment is another factor contributing to the very large increase in the normalization factors for 2020.

Accordingly, we believe that CMS should use more years of data to estimate the normalization factors. As shown in the graphs below, the red lines – which are linear functions that fit the 2012 to 2018 data – appear to be a more accurate representation of the values for 2012 to 2018 than the green lines, which are linear functions that fit the 2014 to 2018 data, as CMS has proposed.[22]

[21] Wakely Consulting Group. Increased ESRD beneficiary enrollment flexibility presents a potential financial challenge for Medicare Advantage Plans in 2021. February 2019.
[22] The 2012 and 2013 data points are from Part II of the 2019 Advance Notice. Because CMS is using the same PCC model that it proposed in 2019, the same data points for 2012 and 2013 can be used for this analysis.

Were CMS to use the 2012 to 2018 data points to estimate the trend, the normalization factor for 2020 for the PCC model and the 2017 model would be 1.047 and 1.050 respectively, rather than the 1.069 and 1.075 figures estimated by CMS using the 2014 to 2018 data.





AHIP strongly recommends that CMS use 2012 to 2018 data to determine the normalization factor, given that: 1) data from 2016 to 2018 are outliers, 2) the risk score increases appear to be stemming from the use of ICD-10 codes, and 3) as a general principle, CMS should use more data points in order to have more stable estimates of normalization. Using the 2014 to 2018 data points runs the risk of over-normalizing for 2020 by setting the normalization factor too high. We are concerned that CMS is placing too much weight on the ICD-10 codes by not using the 2012 and 2013 data points to estimate the normalization trend. In addition to recalibrating the risk model using more recent data, as noted elsewhere, we urge the Agency to work collaboratively with industry on these and other changes to the risk model well before publication of the rate notice. We also encourage CMS, prior to the 2021 Advance Notice, to release information on the impact of recalibrating the risk adjustment model using only years of data in which ICD-10 has been fully implemented (i.e. 2016 and later).

Normalization Factor for the ESRD Dialysis Model and Functioning Graft Model (pp. 39-41). CMS proposes a normalization factor of 1.059 for the dialysis model and 1.084 for the functioning graft model. These normalization factors are estimated based on using 2014 to 2018 data. As discussed above, we believe that CMS should estimate the normalization factors for both of these models using 2012 to 2018 data.

Section N. Encounter Data as a Diagnosis Source for 2020 (pp.42-43)

For 2020, CMS is proposing to increase the percentage of risk scores based on diagnoses submitted through the EDS to 50 percent, up from 25 percent in 2019. In addition, CMS is linking the phase-in of encounter data with the phase-in of the risk model that accounts for the total number of conditions of an individual. As in 2019, CMS is proposing to use only encounter data in the 2020 PCC model, which accounts for the total number of conditions of an individual and must by law be fully phased in by 2022. CMS is also proposing to continue supplementing encounter data-based risk scores with inpatient diagnoses submitted to RAPS.

AHIP members appreciate the need for CMS to capture information about MA treatment and cost patterns and are fully committed to the submission of complete and accurate MA encounter data. Since 2012, our members have worked diligently to achieve this goal through a broad range of informational technology, management, operations activities that have required significant investment. CMS has continued to offer MA plans technical support to address compliance requirements and ongoing operational issues with EDS through regular webinars, listening sessions, and Health Plan Management System memoranda, including one training event.

Despite these efforts, operational problems and uncertainties with EDS persist. Although CMS has been collecting encounter data since 2012, the Agency has to date failed to address recommendations made by the Government Accountability Office (GAO) in 2014 and 2017 to demonstrate the encounter data are complete, accurate, and reliable before being used as the basis for payment. Ongoing operational deficiencies and lack of certainty undermine the stable funding environment that is critical to the growth and enhancement of the MA program, and limit the ability of plans to achieve other Administration goals such as implementing more flexible benefit designs and expanding the offering of more patient-centered supplemental benefits. We are also concerned that

the Administration appears to see the transition to encounter data as an explicit method to reduce MA funding.

Lower Encounter Data-Based Risk Scores. Over the past several years, numerous independent studies have found that MA plan risk scores calculated using encounter data are lower than those calculated using RAPS. Most recently, in its 2018 March Report to Congress MedPAC reported a 2 percent discrepancy between 2016 risk scores calculating using encounter data vs. RAPS.[23] MedPAC found that 7 percent of beneficiaries had a lower encounter data-based risk score. While MedPAC did not look at differences across plan types, earlier studies have found that the discrepancy is much larger among plans with more complex members such as Special Needs Plans (SNPs).[24]

Lower MA Payments Achieved through the Increased Use of Encounter Data. Despite statements in the 2016 Final Notice that "the [risk] scores should be similar" between encounter data and RAPS because "the encounter data system does not change the definition of acceptable diagnoses or limit their submission," CMS is advancing its policy to base the risk score calculation on encounter data in full knowledge it will reduce MA plan risk adjustment payments. While there are several potential factors that could explain lower risk scores calculating using encounter data, one is structural and by design: an analysis by Wakely Consulting Group found that Medicare FFS risk scores are 3 percent less using the EDS filtering logic than using the existing RAPS based filtering logic.[25]

The President's Budget for FY 2019 proposed fully phasing in the use of encounter data for risk adjustment, estimating it would reduce MA spending by $11.1 billion over 10 years. For 2020, CMS projects that increasing the use of encounter data from 25 percent in 2019 to 50 percent will reduce MA plan payments by 0.06 percent year-over-year. These two negative impact estimates, and the characterization in the President's Budget that using encounter data would "eliminate excessive payment" to MA plans, suggest that CMS intends to use encounter data to reduce MA program funding.

Reducing the financial resources available to MA plans in this way could undermine other recent policies being promoted by the Administration to leverage private sector innovation in the Medicare program, such as through flexible benefit design and a broader array of supplemental, person-centered services. We therefore strongly oppose the use of encounter data as a means to reduce payments to MA plans.

Persistent CMS Operational Issues with Encounter Data. Although we acknowledge the efforts made by CMS to increase communication with the industry regarding EDS, the persistent nature of operational issues with encounter data indicate that more stakeholder engagement is necessary. CMS' operational issues have prevented plans from assessing and improving the completeness of their

---

[23] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. March 2018.
[24] Bell, Deanna, Koenig, David, Mills, Charlie. Medicare Advantage's transition from RAPS to EDS risk scores: 2017 impact. Milliman White Paper. February 2018. Available at: http://us.milliman.com/uploadedFiles/insight/2018/Medicare-RAPS-to-EDS-2017.pdf
[25] Wakely Consulting Group. Impact of EDS on MA risk scores. September 2016. Available at: http://www.wakely.com/wp-content/uploads/2016/08/Impact-of-EDS-on-MA-Risk-Scores-White-Paper.pdf

encounter data submissions in a timely fashion, evaluating the discrepancies between encounter data and RAPS-based risk scores, and reconciling past payments. By increasing the use of encounter data without fully resolving these issues, CMS holds MA plans accountable to a higher standard for encounter data completeness than the Agency itself is willing to meet.

These ongoing operational issues are best illustrated through the history of the MAO-004 report, which identifies the diagnoses that will be used by CMS to calculate risk scores after application of the Agency's filtering logic. This report was first issued in December 2015 and is now in its fifth iteration. Although the report is produced on a monthly basis, CMS has repeatedly delayed the release of the reports for weeks to months at a time.

The chart below compares the timeline for CMS corrections to the MAO-004 reports and the resulting impact on the timeline for reconciling the final PY2016 payment. It is important to note that CMS has indicated a *fourth* final reconciliation will be conducted for PY2016 (and a third for PY2017) as a result of encounter data records that were submitted prior to the submission deadline being excluded from the last reconciliation due to CMS processing issues.

Timeline of CMS Issuing MAO-004 Encounter Data Return Files and Reconciling Final PY2016 Payment, 2014-2019

EDS Return Files (MAO-004s)	PY2016 Payment Reconciliation
Nov 2014: CMS announces files will be issued	**Jan 2017:** Original EDS submission deadline
Dec 2015: CMS issues files	**May 2017:** 1st EDS extended deadline
Oct 2016: CMS re-issues files (Phase II)	**Oct 2017:** Interim final payment reconciliation
Mar 2017: CMS re-issues files (Phase III)	**Apr 2018:** 2nd EDS extended deadline
May 2017: CMS re-issues files (Phase III v2)	**Jul 2018:** 2nd interim final payment reconciliation
Apr 2018: CMS re-issues files (Phase III v3)	**Aug 2018:** 3rd EDS extended deadline
Jan-Aug 2018: CMS delays in issuing files	**Sep 2018:** 4th EDS extended deadline
Jul 2018: CMS identifies errors in files	**Dec 2018:** 3rd final payment reconciliation
Jan 2019: CMS indicates errors not yet corrected	**Jan 2019:** CMS identifies error in reconciliation
	TBD: 4th final payment reconciliation?

We continue to believe that, since CMS issues the MAO-004 report on a monthly basis – in contrast to RAPS return files, which are provided on a daily basis – it is difficult for plans to identify errors in their submissions and resubmit data in a timely fashion. We recommend that CMS, in addition to fixing all of the known errors in the MAO-004 reports, issue the MAO-004 reports on a more frequent (e.g., weekly) basis.

GAO Recommendation. As we have noted in prior comments to the Agency, GAO released a report in January 2017[26] that updated its July 2014[27] study on the steps CMS has taken to validate MA encounter data. At that time, GAO determined that CMS had yet to undertake activities that fully address encounter data accuracy, and that numerous stakeholders were concerned with CMS ability to properly identify diagnoses used for risk adjustment. GAO concluded that, "CMS should implement GAO's July 2014 recommendation that CMS fully assess data quality before use," including for payment purposes. CMS has failed to implement these recommendations to date.

MedPAC has recognized this deficiency as well, and as a result has begun to develop its own metrics and methodology for conducting such an evaluation.[28,29] Based on its preliminary analysis, MedPAC has expressed concern with the completeness of encounter data across various sites of service.

Pause the Transition to Encounter Data and Increase Industry Engagement. We support CMS in continuing its policy of supplementing EDS with inpatient diagnoses from RAPS. However, until CMS has shown that the encounter data are complete and accurate per GAO's recommendations, we believe it is inappropriate for CMS to increase the use of encounter data above its current level of 25 percent. In addition, as discussed above and in prior comments to the Agency, the discrepancy between risk scores calculated using encounter data versus RAPS requires that CMS calculate both encounter data and RAPS-based risk scores using the 2017 CMS-HCC model and the 2020 PCC model, and blend these risk scores together within each model – this approach would represent a 'true blend' of the encounter data with RAPS, otherwise CMS will be calculating fundamentally different risk scores using the two different risk adjustment models, as they are based on different filtering logic.

Further, it is critical for CMS to engage in more frequent and structured collaboration with the industry to address current and future operational and policy issues related to EDS. Lack of clear guidance related to EDS and ongoing operational issues indicate that the current process CMS uses to manage EDS is insufficient to support encounter data as the basis for the risk adjustment system. We recommend that CMS engage in more direct dialogue with stakeholders.

---

[26] Government Accountability Office. Medicare Advantage: Limited progress made to validate encounter data used to ensure proper payments [GAO-17-223]. January 2017. Available at: http://www.gao.gov/products/GAO-17-223
[27] Government Accountability Office. Medicare Advantage: CMS should fully develop plans for encounter data and assess data quality before use [GAO-14-571]. July 2014. Available at: https://www.gao.gov/products/GAO-14-571
[28] Medicare Payment Advisory Commission. Medicare Advantage (MA) encounter data validation and potential uses [Presentation]. April 5, 2018.
[29] Medicare Payment Advisory Commission. Medicare Advantage encounter data [Presentation]. November 2, 2018.

Attachment VI. Draft CY 2020 Call Letter

Section I – Parts C and D

Annual Calendar (pp. 101-106)

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

Given the importance of ensuring timely and proper implementation of several key Bipartisan Budget Act of 2018 (BBA) provisions in 2020 (e.g., expanded use of telehealth in MA basic benefits and expanded MA supplemental benefits for chronically ill enrollees), we recommend that CMS move up relevant timelines for issuance of sub-regulatory guidance. For example, CMS should release the final 2020 Medicare Communications and Marketing Guidelines in early May (rather than mid to late June as reflected in the annual calendar). This would ensure that plans have the guidance and lead time needed to implement important changes for 2020.

Enhancements to the 2020 Star Ratings and Future Measurement Concepts

Measure Updates for 2020 Star Ratings (pp. 109-111, 126)

Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D). For 2020 Star Ratings, CMS proposes to apply a new denominator rule to account for all CMRs received during the measurement period. Specifically, CMS proposes that plans continue to exclude beneficiaries enrolled in an MA plan's MTM program for less than 60 days during the measurement year if they did not receive a CMR within this timeframe but include them in both the denominator and the numerator if they received a CMR within this timeframe. We support this change.

Statin Use in Persons with Diabetes (SUPD) Measure (Part D). CMS proposes to increase the weight of this measure from 1 to 3 as an intermediate outcome measure for 2020 Star Ratings. This measure is the percent of Medicare Part D beneficiaries 40-75 years of age who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period. In the 2019 MA and Part D Final Rule (CMS-4182-F) published in April 2018 (83 FR 16440), CMS explained its reason for proposing to re-categorize this measure as an intermediate outcome measure for 2020. On page 16577 of the Final Rule CMS states that "[r]eceiving multiple fills indicates the patient continues to take the medication and therefore suggests adherence." We do not agree with CMS' rationale. The numerator of this measure is focused on a single fill of a statin medication during the measurement period, which is not an indicator of multiple fills or continuous medication adherence. We believe that this measure should continue to be categorized as a process measure and receive a weight of 1 for 2020. We therefore recommend that CMS not move forward with this proposed change.

Improvement Measures (Part C & D). In Table 1 on pages 110-111 CMS includes all the Star Ratings measures eligible to be used by in calculating the Part C and Part D improvement measures

for 2020. To improve clarity, we recommend that for future proposals, CMS also identify which measures it is proposing to add or remove from the improvement measure sets. Additionally, we encourage CMS to work with plans to identify ways to improve the improvement measure calculation to better reflect progress in plan performance.

Members Choosing to Leave the Plan (Parts C&D). CMS proposes to use additional data to identify beneficiaries leaving a plan due to a move outside of the contract service area in order to exclude them from these measures. We support CMS' plans and request that the Agency provide more details about these additional data sources.

Temporary Removal of Measure from the 2020 Star Ratings (p. 111)

Controlling High Blood Pressure (Part C). CMS proposes to remove this measure from 2020 Star Ratings due to the release of new hypertension treatment guidelines and substantive changes to the measure by the National Committee for Quality Assuarance, including the revised blood pressure target and several structural modifications. We support the move of this measure from Star Ratings to the display page for 2020 and 2021 given these substantive changes.

2020 Star Ratings Program and the Categorical Adjustment Index (pp. 111-119)

CMS proposes to continue the use of the Categorical Adjustment Index (CAI), which was implemented as an interim analytic adjustment to account for disparities in MA plan performance associated with socioeconomic status (SES) and includes adjustments based on low-income subsidy and dual eligible (LIS/DE) and disability status. CMS will continue to apply a set of four criteria in place since 2017 to determine which Star Ratings measures are candidates for use in calculating the CAI.

In a methodological change from prior years, CMS is proposing to eliminate the following two criteria previously used to select measures from the candidate measures set used to calculate the CAI:

1) a median absolute difference between LIS/DE and non-LIS/DE beneficiaries of 5 percentage points or more, and/or
2) the LIS/DE subgroup performed better or worse than the non-LIS/DE subgroup in all contracts.

AHIP supports the continued use of the CAI in the Star Ratings program while CMS develops a long-term solution to address this problem. AHIP further supports the CMS proposal to eliminate the criteria noted above for selecting measures from the candidate measure set to use in calculating the CAI. By eliminating these criteria, CMS is greatly expanding the number of measures used to calculate the CAI and allowing the CAI to reflect both within-contract and across-contract differences in performance based on SES. Such an approach is consistent with a finding by the Assistant Secretary for Planning and Evaluation (ASPE) that contracts with a high proportion of beneficiaries with low SES typically achieved lower quality scores and were less likely to qualify for

bonus payments.[30] In addition, this approach increases the CAI values applicable to contracts with a high proportion of LIS/DE and disabled beneficiaries.

However, although we support this methodological change, we also recognize that this change could lead to a material impact on Star Ratings for contracts with a low proportion of LIS/DE and disabled beneficiaries. As a result of the change, the CAI values for these contracts will be substantially more negative and more contracts could receive a negative adjustment in 2020 that reduces their overall Star Rating in comparison to 2019.

As the CAI is an interim analytic adjustment, we believe that it is crucial for CMS to hold plans harmless from reductions in Star Ratings due to the CAI, particularly in 2020 as this will be the first year that this new methodology is implemented. In addition, we recommend that CMS release more detailed information on the data underlying the CAI calculation to enable a more comprehensive analysis of changes in the CAI methodology year-over-year.[31]

In addition, CMS indicated in a February 6 memorandum addressed to MA and Part D plans entitled "End of Moratorium on Authority to Terminate Medicare Advantage Organization Contracts Based on Low Star Ratings," that it plans to pursue its policy to terminate the contract of an organization that receives Part C summary Star Ratings below 3 stars in CYs 2020, 2021, and 2022, or Part D summary Star Ratings below 3 stars in the same 3-year period. Until the related ASPE report is released this fall and CMS has fully implemented a long-term solution to address SES disparities in the Star Ratings program based on its findings, we urge CMS not to terminate contracts based solely on Star Ratings performance.

Additional Adjustments for Puerto Rico Plans

We note that CMS omitted from the draft Call Letter a section on additional adjustments for plans offered in Puerto Rico to address the lack of an LIS indicator. For 2017 through 2019, CMS has employed two additional adjustments for Puerto Rico in recognition of the unique challenges faced by MA plans operating on the island: 1) approximating LIS-eligible beneficiaries to allow Puerto Rico-based plans to be eligible for adjustments under the CAI, and 2) implementing a differential weighting scheme for the medication adherence measures for these organizations in calculating the overall and summary Star Ratings. These adjustments were also codified for 2021 Star Ratings in the 2019 MA and Part D Final Rule published in April 2018. AHIP is supportive of both adjustments and assumes that CMS' intent is that the policy will carry over from prior years and be effective for the 2020 Star Ratings. We recommend that CMS confirm that its current policy remains unchanged for 2020 Star Ratings in the final Call Letter.

---

[30] Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Report to Congress: Social risk factors and performance under Medicare's value-based purchasing programs. December 2016.

[31] In the Star Ratings data released each year, CMS reports which "Final Adjustment Category" is applicable to each contract. However, these data are not granular enough to understand how changes to the Final Adjustment Categories could impact Star Ratings. We request that CMS report the proportion of LIS/DE and disabled beneficiaries in each contract as well as the assigned LIS/DE decile and disability quintile in addition to the Final Adjustment Category.

Extreme and Uncontrollable Circumstances Policy (pp. 119-126)

CMS proposes to continue its policy of adjusting Star Ratings to account for the effects of disaster-related events that occurred during the 2018 performance period. CMS provides details regarding adjustments that would be made to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey, and other Star Ratings measures, and describes rules for handling improvement measures and missing data for affected contracts. In addition, CMS proposes to continue making changes to cut point calculations for non-CAHPS measures to minimize impacts.

We support CMS' proposal to adjust 2020 Star Ratings to account for the effects of disaster-related events that occurred during the 2018 performance period. However, we have the following additional comments and related recommendations:

- *Doubly-Affected Contracts*. In the draft Call Letter, CMS describes its proposed calculations for doubly-affected contracts (e.g., contracts impacted in 2018 that were also affected by disaster in 2017). CMS indicates that these contracts "would receive the higher of the 2020 Star Rating or what the 2019 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2017 disaster for each measure." CMS explains in part that its proposal is intended to limit "older data continuing to be pulled forward in the Star Ratings." While we understand CMS' concern about use of older data, we believe the equitable relief resulting from the use of this older data outweighs the Agency's concern. CMS' proposed approach would adversely impact doubly-affected contracts since the Agency will only be comparing and choosing the higher rating (and corresponding measure score) from two measurement periods that have both been impacted by disasters. Measurement periods impacted by disasters mask and do not reflect true plan performance. To minimize unintended adverse impacts on doubly-affected contracts, we recommend that CMS revise its proposed methodology to also include results from an unaffected measurement period (e.g., measurement period prior to the two measurement years impacted by disaster-related events).
- *Future Data Releases*. CMS indicates in the draft Call Letter that it will provide additional information about contracts eligible for disaster-related adjustments in the future. We appreciate CMS' plans to provide these data and recommend that the Agency provide as much detail as possible about the contracts affected and adjustments made to measure scores as well as to other aspects of the program.
- *Hold-Harmless*. We continue to recommend that CMS consider a hold-harmless provision to ensure that adjustments made due to this policy including changes to the cut point calculations do not disadvantage any plans.

New 2020 Display Measures (pp. 127-130)

MPF Price Accuracy (Part D). As indicated in the 2019 final Call Letter, CMS proposes to continue to include the current Medicare Plan Finder (MPF) Price Accuracy measure in Star Ratings for 2020 and 2021 using the same methodology used for the 2019 Star Ratings. At the same time, CMS proposes to add a modified version of the measure to the display page for 2020 and 2021 and to

Star Ratings for 2022. As we have indicated in previous comments, due to the frequent fluctuations in drug prices common to the pharmaceutical marketplace, it remains challenging for plan sponsors to ensure the MPF is updated immediately to reflect the market price of a drug. We are concerned that the proposed changes could penalize plans that are continuing to make substantial investments in the accuracy of their cost reporting. We continue to recommend that the MPF price accuracy measure be aligned with pricing practices inherent in the pharmaceutical marketplace and that CMS consider allowances for updating the MPF based on rapid drug price swings. CMS should also assess the costs to the program (through higher plan bids) that will arise from additional investments that may be required for plans to comply with the proposed revisions to the methodology for this measure.

Retired Display Measure for 2020 (p. 130)

Transition Monitoring Program Analysis (TMPA) and Formulary Administration Analysis (FAA) (Part D). CMS proposes to discontinue these two Part D display measures. In the draft Call Letter, CMS explains that it has seen an improvement in plan formulary administration and transition practices and that these measures duplicate other CMS oversight monitoring activities, which has led to an increased administrative burden on plans. We agree and support CMS' decision to retire these Part D display measures.

Forecasting to 2021 and Beyond (pp. 131-141)

Potential Changes to Existing Star Ratings and Display Measures (pp. 132-137)

Medication Reconciliation (Part C). Starting with the 2021 Star Ratings, CMS proposes that it would use the medication reconciliation data that is collected under the Transitions of Care display measure from HEDIS 2020 to calculate the score for the Part C Medication Reconciliation Stars measure. We do not support CMS' proposal. We are concerned about the data collection challenges and other issues associated with applying data collected for one measure to an entirely separate measure. We also believe that this proposed change is substantive and should therefore be proposed through the Federal Register rulemaking process. Furthermore, consistent with CMS' codified Star Ratings requirements, the modified version of this existing measure should be placed on the display page for at least two years to assess and resolve reliability and other issues that may impact plan performance. We therefore recommend that CMS not move forward with its proposal for 2021 Star Ratings.

Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D). CMS requests feedback on its proposal to change the frequency of release of Patient Safety reports to a quarterly instead of a monthly basis. We understand that the availability of these reports on a monthly basis aids plans significantly with their performance improvement and monitoring efforts. We therefore recommend that CMS continue to issue these reports on a monthly basis.
Potential New Measure Concepts (pp. 138-141)

Physician/Plan Interactions (Part C & D). In the draft Call Letter, CMS indicates that it welcomes feedback on the feasibility of developing and implementing a measure, as an alternative to physician

survey measures, that would relate to plan coverage and payment decisions, claims processing issues, and other common administrative processes that plans have in place. We have the same concerns with this potential new measure concept as we have with survey measures of physicians' experiences in the Star Ratings system. These types of measures place a high burden on providers and plans which would likely lead to unreliable results. We recommend that CMS not move forward with this potential new measure concept. Instead, CMS should focus on considering evidence-based measures, including quality measures focused on health outcomes for future Star Ratings.

Removal of Measures from the 2022 Star Ratings (pp. 141-143)

Appeals Auto-Forward and Appeals Upheld (Part D). CMS proposes to remove these Part D appeals measure from 2022 Star Ratings. CMS indicates in the draft Call Letter that the reliability of these measures has "declined over time" and that it has "not found this pattern to exist with other Star Rating measures, including the Part C appeals measures." As we have noted in prior comments on this subject, AHIP is concerned about the inclusion of measures in the Star Ratings system that focus on compliance with specific program requirements or enforcement actions. Such measures are also inconsistent with the Agency's continuing efforts to move quality measurement programs across the health care delivery system toward a core set of clinical, evidence-based performance measures. Accordingly, we support CMS' proposal for removing the two Part D appeals measures from Star Ratings. In addition, we request that the Agency evaluate and provide information about the impact of the removal of these two measures from the Part D measure set on plan performance and ratings. Finally, given CMS' concerns about the reliability of these two measures and its plans to retire them, we recommend that the Agency consider reversing its decision in the 2019 MA and Part D Final Rule published in April 2018 that increases their weight to 2 for 2021 Star Ratings. CMS instead should maintain the weight at 1.5.

Other Star Ratings Comments

Pre-Determined Cut Points. CMS does not currently establish pre-determined cut points for measures in advance of the measurement period. AHIP continues to urge CMS to: develop cut points and publish them well in advance of the measurement period; ensure that the cut points reflect meaningful differences; and limit year-to-year cut point changes to minimize wide fluctuations. We continue to believe the elimination of pre-determined thresholds has impeded CMS' goal of promoting continued quality improvement. As plans have transitioned to value-based arrangements with providers, setting goals is essential to help parties assess the effectiveness of their efforts to improve quality of care and reduce costs while maintaining high performance and rating levels. Moreover, setting cut points in advance of the measurement period would help to simplify the Star Ratings program and reduce burdens on providers contracting with multiple plans who otherwise may face varying and conflicting quality performance metrics on the same quality measures. We believe that establishment of pre-determined thresholds is the best means to ensure transparency, predictability, stability, and quality improvement. Pre-determined cut points also promote a key Administration goal of reducing unnecessary regulatory burdens.

Weighting of Patients' Experience and Complaints and Access Measures. On page 111 of the draft Call Letter, CMS notes that starting with the 2021 Star Ratings, the Patients' Experience and Complaints and Access measures will receive a weight of 2. We recognize that this proposal to increase the weight of these measures from 1.5 to 2 was finalized in the 2019 MA and Part D Final Rule published in April 2018. Our members believe that beneficiary engagement and patient experiences are critical aspects for achieving and maintaining high quality care. We remain concerned, however, about the impact of increasing the weight of measures that are based solely on survey data in the Star Ratings program. As we have previously commented, measure scores based solely on surveys may not be a true reflection of plan performance. Increasing the weight of these measures also does not align with CMS' guiding principles for the Star Ratings program set forth in the 2019 Final Rule to ensure that data used in the Star Ratings program are complete, accurate, and reliable and minimize unintended consequences. Further, we note that methodological limitations of the CAHPS measures do not support a greater weight for patient experience measures. Because of the limited sample size for administering the CAHPS survey and the tight clustering of CAHPS measure cut points, MA contracts with marginally different performance can receive measure scores that are several star levels apart.[32] MedPAC has recently noted its concerns with narrow differences in CAHPS measure results leading to large differences in measure-level Star Ratings.[33] For the concerns raised above, we urge CMS to provide another public comment opportunity on this issue.

***Section II - Part C** (p. 147)*

Total Beneficiary Cost (TBC) (pp. 149-152)

The draft Call Letter indicates that for CY 2020, CMS is proposing to continue to use a TBC change amount of $36.00 per member per month (PMPM) for most plans. In the 2019 draft Call Letter, CMS had indicated that it was considering eliminating TBC in future years. The draft Call Letter does not reference this proposal. We believe eliminating TBC would encourage plan innovation and competition and would allow plans more flexibility to offer benefits that meet the needs of their members. Therefore, we continue to recommend that CMS eliminate TBC and work with plans to identify alternative ways to monitor possible increases in cost sharing or decreases in benefits from one year to the next.

Potential Changes to MOOP and Cost Sharing Standards for CY 2021 (pp. 159-161)

CMS requests feedback on potential changes to MOOP and cost sharing standards for 2021 and subsequent years. The Agency specifically states that it is considering establishing a third (intermediate) MOOP limit and providing additional flexibilities for service category cost-sharing standards for plans that elect to use the intermediate or lower MOOP. AHIP would support these flexibilities. These changes to the MOOP and cost-sharing standards would enhance the ability for plans to offer benefits that are of greater value to their beneficiaries.

---

[32] For example, the difference between a 1 Star rating and a 5 Star rating for the CAHPS customer service measure in the 2018 Star Ratings was only 5 percentage points (a score of less than 88 percent for 1 Star and greater than or equal to 92 percent for 5 Stars).

[33] Medicare Payment Advisory Commission. Examining the Medicare Advantage quality bonus program [Presentation]. November 2, 2018.

Medicare-covered Opioid Treatment Program Services Beginning in CY 2020 (pp. 158-159)

CMS states that the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act has established coverage of opioid use disorder treatment services furnished by Opioid Treatment Programs (OTPs) under Medicare Part B. As such, MA plans will be required to provide these services in 2020. AHIP encourages CMS to provide specific guidance for this benefit as soon as possible.

Special Supplemental Benefits for the Chronically Ill (pp. 161-164)

In the draft Call Letter, CMS addresses the Special Supplemental Benefits for the Chronically Ill (SSBCI), as added by the BBA, that MA plans will be allowed to offer starting in 2020. These benefits include items and services that are not primarily health related and that can be targeted to meet the individual enrollee's specific medical condition and needs.

AHIP is very supportive of the additional flexibilities afforded to plans through the use of SSBCI. We provide the following comments and additional recommendations on CMS' guidance on the SSBCI.

- *Eligible Chronic Conditions*. Under the BBA, a chronically ill enrollee must meet 3 criteria: (1) the enrollee has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee; (2) the enrollee has a high risk of hospitalization or other adverse health outcomes; and (3) the enrollee's condition(s) requires intensive care coordination. For 2020, CMS proposes to consider any enrollee with a condition identified as a chronic condition under section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual (MMCM) as meeting the first eligibility criterion. We support CMS' proposal to include these conditions but recommend that the Agency allow MA plans more flexibility in 2020 for identifying other chronic conditions that can meet the first criterion. We believe the conditions identified in Chapter 16b of the MMCM do not represent the entirety of chronic conditions that would be appropriate to consider under the SSBCI.
- *Advisory Panel.* CMS indicates that the Agency will convene a technical advisory panel by 2021 to consider updates to the list of eligible chronic conditions for SSBCI. We believe that the advisory panel that CMS proposes would be useful and recommend that CMS ensure plan representation.
- *Permissible Benefits.* CMS indicates that plans will have "broad discretion" in developing SSBCI items and services. However, the Agency provides only a very limited list of examples of permissible benefits. To ensure that plans have all of the information necessary for bid submissions and to minimize the risk of rejections during the annual benefit package review, we urge CMS to release more detailed guidance on the scope of permissible benefits as soon as possible. Furthermore, CMS indicates the SSBCI items or services "may <u>not</u> include capital or structural improvements to the home of the enrollee that could potentially increase property value." We are concerned this proposed limit could be used to prevent plans from offering certain high-value benefits for enrollees with particular chronic illnesses. Given that the statute does not include this limitation, we believe CMS should allow plans

flexibility to determine the appropriate package of benefits that would best meet their enrollees' needs.

- *Marketing and Model Materials.* Supplemental benefits must be described in member materials per MA program requirements. Since these benefits may be offered non-uniformly, AHIP members would appreciate additional guidance as soon as possible regarding how these benefits should be described in member materials. Further, we request that CMS provide more guidance on its proposal to prohibit inducement.

In summary, we recommend CMS should offer both flexibility and guidance in the types of SSBCI benefits that will be allowed to be offered as soon as possible.

Provider Directories (p. 164)

CMS indicates that it will continue to focus on MA provider directories and work with stakeholders to improve provider directory accuracy. We appreciate CMS' recognition of the complexities surrounding provider directory accuracy, including the lack of a centralized repository for provider directory data. We also appreciate CMS' consideration that the validity and accuracy of MA provider directories is contingent upon receipt of updated and accurate information by providers. Maintaining accurate provider directories is a shared responsibility. It requires a commitment from both health plans and providers to ensure consumers have the information they need and that the directory information is updated in a timely and accurate fashion.

AHIP and our members are committed to working with providers and other stakeholders to highlight the challenges to maintaining accurate and up-to-date provider directories, share strategies and best practices for maintaining and updating provider directories, and identify a national solution to this issue. In the meantime, we continue to recommend that CMS not penalize plans undertaking good faith efforts to improve their provider directories.

D-SNP Administrative Alignment Opportunities (pp. 165-166)

In the 2020 draft Call Letter, CMS states its continued commitment to provide administrative flexibility to aid efforts by state Medicaid agencies and MA plans to use D-SNPs to integrate Medicare and Medicaid coverage. CMS also describes efforts to encourage integration, including those in the CY 2020 MA and Part D proposed rule. Additionally, CMS states that for zero-dollar cost sharing SNPs, CMS has allowed plan materials and MPF to reflect the $0 for all Medicare Parts A and B benefits. Furthermore, in three states CMS is working to develop state-specific models of integrated member materials for Fully Integrated Dual Eligible SNPs.

We appreciate the Agency's efforts to further integrate Medicare and Medicaid benefits for dually eligible beneficiaries and enhance beneficiary experience. We commend the work CMS is doing in this area and encourage the Agency to continue to work with states and plans to enhance those efforts.

Medicare Advantage Organizations Crossing Claims Over to Medicaid Agencies (pp. 169-171)

CMS welcomes comments on ways to automate the Medicare claims crossover process for dually eligible individuals in MA plans. We understand that there are challenges to implementing a standardized process. For example, in states where Medicare and Medicaid integration is limited, information sharing can be extremely difficult. We recommend that CMS work with stakeholders to identify existing challenges and collaborate to identify best practices and practical solutions.

Interoperability and Prior Authorization Coordination (p. 171)

CMS encourages all payers, including MA plans and Part D sponsors, to align with the Da Vinci Project's Coverage Requirements and Documentation Rules Discovery work to promote interoperability and prior authorization coordination. AHIP believes that moving toward industry-wide adoption of electronic prior authorization transactions based on existing national standards could streamline and improve the process for all stakeholders. Additionally, making prior authorization requirements and other formulary information electronically accessible to health care providers at the point-of-care in electronic health records (EHRs) and pharmacy systems as much as possible will improve process efficiencies, reduce time to treatment, and potentially result in fewer prior authorization requests because health care providers will have their patient's coverage information they need when making treatment decisions. Technology adoption by all involved stakeholders, including health care providers, health insurance providers, and their trading partners/vendors including the EHR systems used by physician practices, is necessary to work toward achieving widespread industry utilization of standard electronic prior authorization processes. Comprehensive end-to-end solutions for automating prior authorization are not yet available. Once they become available it will take time for all stakeholders to migrate to the new technologies. Thus, we believe that incentives by CMS to encourage stakeholders to adopt technologies that can enable standards-based electronic exchange of prior authorization information would help hasten progress and be supportive of the efforts already underway by private payers.

AHIP is in the process of coordinating a demonstration project in 2019 with vendors offering prior authorization automation solutions, health insurance providers, and physician practices to test different approaches and evaluate the impact of scalable solutions that are payer agnostic and as integrated as possible with provider workflow. We are also engaged with CMS in its development of the Document Requirement Look-up Service demonstration that would enable providers to electronically query the steps needed to get coverage of items or services and provide supporting documentation starting with e-prescribing of durable medical equipment. We commend CMS for working with HL7's Da Vinci Project, which includes a number of private payers, as part of this demonstration to further develop data and electronic transaction standards as existing standards are not sufficient to fully automate the process. We note, however, that the Department of Health and Human Services has yet to release its rule on claims attachments. Adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards) would further reduce the administrative burdens associated with prior authorization. We urge CMS to continue its support of the Da Vinci project as it begins its expanded work on quality measurement and other use cases**.**

Section III – Part D

Improving Access to Opioid-Reversal Agents & Access to Medication-Assisted Treatment (pp. 173-175)

CMS encourages Part D plans to reduce cost-sharing for naloxone products by placing them on a generic tier, or on a Select Care tier for plans using that model. CMS also recommends and encourages that Part D plans promote the co-prescribing of naloxone with opioids, particularly for beneficiaries who are at higher risk of opioid-associated harm.

AHIP agrees that promoting access to naloxone is a critical part of the strategy for addressing opioid-associated harm. Our members have worked closely with CMS and other stakeholders to prevent opioid overuse and misuse, and to treat opioid addiction. However, we have significant concerns about the high and rising prices of these products. For example, Evzio, the automated naloxone self-injection product, increased in price by 652 percent between 2014 and 2017, going from a list price of $575 to $3,750. AHIP believes these high prices are the primary barrier creating potential access issues. Accordingly, we recommend that CMS consider policies that would help to limit unreasonable increases in naloxone list prices, for both brand and generic products, much like the policies CMS has proposed to limit price increases for protected class drugs.

Improving Access to Generic and Biosimilar Medicines (pp. 180-183)

CMS seeks feedback on whether it should consider changing current rules on permissible tier composition in Part D by discouraging or prohibiting Part D plans from including brand and generic drugs on the same tier. Such a policy would require generic drugs to be placed only on generic tiers and brand drugs to be placed only on brand tiers. It would also eliminate the non-preferred drug tier, which currently allows for placement of both high cost generics and brand drugs. The Agency also seeks feedback on other aspects of the proposal, including whether it should require Part D plans to automatically place new generic entrants in a generic tier immediately after launch, how biosimilars should be treated under this policy, and whether generics and biosimilars should be allowed on specialty tiers if they meet the specialty threshold. CMS suggests the goals of these changes would be to encourage utilization of more affordable generics, lower out-of-pocket costs, and reduce beneficiary confusion.

AHIP agrees with CMS' goals. However, we believe that the policy under consideration would not advance these goals. Plan flexibility to promote therapeutically equivalent generic utilization over more expensive brand drugs has contributed heavily to the savings and success of Part D over the past decade. Removing that flexibility could result in higher out-of-pocket costs for all generics and/or less choice for beneficiaries. This is particularly a risk given that high priced generics are becoming increasingly commonplace. Additionally, the success of the Part D program and consistently high beneficiary satisfaction rates suggest there is little need for change. We believe tiering based on drug cost, rather than exclusively based on labels like brand or generic, is actually a more meaningful approach for beneficiaries. As such, AHIP recommends that CMS not consider requiring or recommending such a policy.

However, if CMS determines that the policy is necessary, AHIP recommends the following modifications:

- CMS should not require that Part D plans utilize the new tiering, especially as it could put beneficiary access to low cost generics at risk.
- Under any modified policy, Part D plans should continue to be able to place any drug that meets the specialty drug cost threshold in a specialty tier, regardless of whether it is a brand, generic, or biosimilar.
- For this purpose, biosimilars should not be treated the same as small molecule generic drugs when they are not interchangeable with reference biologic products.
- CMS should not require immediate and automatic inclusion of a new generic entrant in the generic tier; first-to-market generics are often priced high with minimal discounts from their brand products.
- Part D plans should be allowed to use existing Pharmacy and Therapeutics Committee processes to determine tier placement of such generics.
- The policy would require significant changes to implement. Therefore, if CMS were to move forward with the policy despite the serious concerns noted above, the Agency should provide plans with at least two full calendar years to implement (no sooner than CY 2022).

Improving Drug Utilization Review Controls (pp. 186-199)

CMS provides an overview of the steps CMS has and is taking to combat opioid overutilization in Part D, including a CMS roadmap released in June 2018, implementation of the Comprehensive Addiction and Recovery Act of 2016, and improved opioid safety edits introduced for CY 2019. For CY 2020, CMS proposes several opioid related proposals in the draft Call Letter. CMS also notes that it is continuing to work with the Office of the Inspector General to identify potentiator drugs that may pose safety risks when combined with opioids.

AHIP appreciates the Agency's leadership on the opioid issue. We also note that AHIP member plans continue to be critical partners with the Agency in these efforts. Part D plans have been diligently monitoring and collecting data on opioid utilization, which CMS has leveraged to implement opioid policy changes. Part D plans have also been planning and implementing drug management programs for CY 2019 in accordance with CMS regulations and federal legislation. For example, plans can now identify beneficiaries who are potentially at risk for opioid abuse or misuse, conduct clinical case reviews, and take steps to prevent opioid addiction, including implementing a prescriber and/or pharmacy lock-in program. AHIP also appreciates the work CMS has done and continues to do in mitigating the role of opioid potentiators such as gabapentin and pregabalin. We believe this will become of increasing urgency, as the likely introduction of a generic version of pregabalin could potentially increase opioid-associated harms. We also encourage CMS to continue to collaborate and align with other agencies, such as the Substance Abuse and Mental Health Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), to ensure CMS is efficiently addressing the opioid crisis.

Part D Mail Order Auto-Ship Modifications (pp. 199-201)

CMS proposes to permit Part D plans to offer an opt-in, voluntary auto-ship program for refills of established therapies, starting in CY 2020. This program would replace the current affirmative prior consent step required for sending refills that are not initiated by the beneficiary. CMS notes that it expects plans implementing an auto-ship program will include at least two reminders to be sent "well in advance" of each shipment, to ensure beneficiaries have enough time to modify or cancel an order. CMS notes that the Part D plan should send these notices in accordance with the beneficiary's preference. Additionally, CMS expects Part D plans to have a full refund policy for any auto-shipped refills that a beneficiary reports as unneeded or otherwise unwanted, regardless of whether the medication is returned.

AHIP supports the new proposed flexibility. We believe it will allow beneficiaries voluntarily choosing to participate with easier and more timely access to their prescription medications. However, AHIP recommends that CMS finalize this proposal without the requirement for two notifications. We believe that allowing the beneficiary to opt-in to the program and to receive refunds sufficiently protects the beneficiary and disincentivizes waste. If CMS decides that notification is necessary, AHIP recommends that CMS only require one notification rather than two. AHIP also believes that CMS should consider providing plans with additional flexibility in deciding what relevant information may be included in shipping reminders and allowing beneficiaries to remain in the auto-ship program until voluntarily opting out.

Section IV – Medicare-Medicaid Plans

We would like to take this opportunity to recognize and support the work of the Medicare-Medicaid Coordination Office (MMCO). We reiterate our appreciation of the MMCO's efforts to further integrate Medicare and Medicaid benefits for dually eligible beneficiaries and enhance beneficiary experiences. AHIP continues to strongly urge CMS to continue and expand the MMP demonstration.

EPSTEIN
BECKER
GREEN

Attorneys at Law

MEMORANDUM

To: AHIP **From:** Epstein Becker & Green, PC[1]

Date: March 2, 2018

Re: Calculating Medicare Advantage Adjusted Average Per Capita Cost

I. Executive Summary

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

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

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

[1] This memorandum has been prepared by Philo D. Hall, Associate, Thomas E. Hutchinson, Strategic Advisor, and Lynn Shapiro Snyder, Senior Member of the Firm.
[2] *See* MedPAC, Report to the Congress: Medicare Payment Policy, table 13-8, pg 360 (Mar. 2017).
[3] *Id*. at pg. 362.
[4] *Id*.
[5] *Id*. at page 362.

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

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

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

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

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

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

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

[6] Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, Centers for Medicare & Medicaid Services, pg. 29 (April 4, 2011).
[7] *Id*.
[8] SSA § 1853(a)(1)(A)(ii).
[9] *Id*. at § 1853 (a)(1)(B); 42 CFR § 422.304(a).
[10] SSA § 1853(j)(1).
[11] *Id*. at § (n)(1)(B), (n)(2).
[12] *Id*. at § (n)(2)(E)(ii).

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

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

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

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

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

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

[13] Clause (ii) identifies rebasing years. In years that are not rebasing years, the base payment amount is the amount for the previous year, increased by the national per capita MA growth percentage described in 1853(c)(6) for the succeeding year. SSA § 1853(n)(2)(E)(ii)(I).
[14] *Trainmen v. Baltimore & Ohio R.R.*, 331 U.S. 519, 528 (1947).
[15] See, e.g., *Almendarez-Torres v. United States*, 523 U.S. 224, 234 (1998); *INS v. National Center for Immigrants' Rights*, 502 U.S. 183, 189 (1991).
[16] *Demore v. Kim*, 538 U.S. 510, 535 (2003) (O'Connor, J., concurring) (citing *INS v. St. Cyr*, 533 U.S. 289, 308-09 (2001)).
[17] *Trainmen v. Baltimore & Ohio R.R.*, 331 U.S. 519, 529 (1947); *Intel Corp. v. Advanced Micro Devices, Inc*., 542 U.S. 241, 256 (2004) (quoting *Trainmen*).
[18] Pub. L. 97-248.

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

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

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

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

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

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

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

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

[19] 467 U.S. 837, 842-43 (1984) (citations omitted).
[20] Sebelius v. Cloer, 569 U.S. __, No. 12-236, slip op. (May 20, 2013) (internal quotation marks omitted).
[21] *Hartford Underwriters v. Union Planters*, 530 U.S. 1, 6 (2000) (internal quotation marks omitted).
[22] *United States v. Vonn*, 535 U. S. 55, 65 (2002).
[23] *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 81 (2002).
[24] SSA § 1876(a)(4).
[25] *Id.* at § 1876(c)(2)(A) (emphasis added).

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

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

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

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

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

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

[26] *Id.* at § 1876(d) (emphasis added).
[27] *See* Pub. L. 105-33 § 4001.
[28] For the individuals who are not otherwise entitled to Part A through the payment of at least 40 quarters of Medicare taxes, the Secretary is authorized to provide a buy-in for Part A only coverage, the premiums for which are calculated to be the monthly actuarial rate of national benefits and costs payable from the Federal Hospital Insurance Trust Fund for services to individuals age 65 and over. (*see* SSA § 1818(d)). Similarly, for individuals who elect coverage under only Part B, Congress authorized the Secretary to calculate Part B premiums based on the "benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed . . . with respect to such enrollees." (*see* SSA § 1839(a)).
[29] SSA § 1852(a)(1)(B) (emphasis added).
[30] (emphasis added).
[31] (emphasis added).

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

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

The statutory provisions enacted in 1997 that created the Medicare+Choice program[35] extensively, repeatedly and consistently use the language "parts A and B" when referring to the scope of the program. This buttresses the interpretation that CMS is permitted to exclude the costs attributable to beneficiaries enrolled in Part A only when calculating MA benchmarks.

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

IV. Conclusion

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

***

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