MEMORANDUM

To:            AHIP  From: Epstein Becker & Green, PC

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.\(^1\)

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

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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.


3 Id. at pg. 362.

4 Id.

5 Id. at page 362.
Part B." 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.”

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. 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.

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.” 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).

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.” 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 Announce.

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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)\(^\text{13}\)

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”\(^\text{14}\) and can provide little interpretive aid. A heading or title can shed light on a section’s basic thrust,\(^\text{15}\) or on ambiguous language in the text, but it “has no power to give what the text of the statute takes away.”\(^\text{16}\) The heading or title “cannot limit the plain meaning of the text.”\(^\text{17}\) 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”\(^\text{18}\) which first established AAPCC and defined it under section 1876(a)(4) as follows:

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\text{[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) }
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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).


\(^{18}\) 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.”

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.” 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.”

The statutory interpretive canon, expressio unius est exclusio alterius, states that “expressing one item of [an] associated group or series excludes another left unmentioned.” An essential ingredient of an expression-exclusion demonstration is a “series of terms from which an omission bespeaks a negative implication.” 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,” 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.” Eligibility for these 1876 plans was limited to...

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

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.” 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.” 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.” 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.”

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.”

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 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.” 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.

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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”).