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Mr. Demetrios Kouzoukas, Principal Deputy Administrator and Director, Center for Medicare
Ms. 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) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part I, CMS-HCC Risk Adjustment Model, and Part II; Contract Year 2021 Part C Benefits Review and Evaluation

Dear Mr. Kouzoukas and Ms. Lazio:

America's Health Insurance Plans (AHIP)[1] appreciates the opportunity to comment on Parts I and II of the Advance Notice for Calendar Year (CY) 2021 for Medicare Advantage (MA) and Part D. We also include comments on the CY 2021 Part C Benefits Review and Evaluation (Part C bidding instructions).

Approximately 24 million people – 35% of those eligible for Medicare – choose MA because it delivers better services, better access to care, and better value. Similarly, Medicare Part D has been a model of consumer choice and market competition that has improved access to prescription drugs and reduced out-of-pocket costs for tens of millions of seniors. Currently, 47 million Americans are covered under Part D, with more than 21 million receiving their benefits through an MA plan and more than 25 million through a stand-alone Prescription Drug Plan. MA 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.

We strongly agree with CMS' statement in the Advance Notice that these programs have demonstrated the value of private sector innovation and creativity. We commend CMS for recognizing the success of MA and Part D plans in providing enrollees with choices so they can find health care that best meets their needs. We also commend the agency's ongoing commitment to "make changes that promote greater innovation, transparency, flexibility, and program simplification." Several regulatory proposals for 2021, issued in tandem with the Advance Notice, promote these goals to improve affordability and choice. They include:

- **Enhanced Network Flexibility**: We appreciate and support CMS' policies to enhance network contracting options to promote innovation, increase access, and reduce costs for people with end-

[1] AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

stage renal disease (ESRD), those using emerging telehealth technologies, and those living in rural areas.

- **Part D Flexibility**: Allowing Part D plans more flexibility enhances the use of market-based tools to lower costs for certain high-priced drugs.
- **Supplemental Benefit Flexibility**: New CMS provisions that clarify and enhance the ability of MA plans to offer supplemental benefits will enable health insurance providers to better address social barriers to care and other needs of chronically ill enrollees.

AHIP will separately address these and other proposals when we submit comments on the proposed rule for 2021 and 2022.

However, AHIP and our member health insurance providers have significant concerns with certain proposals in the Advance Notice and bidding instructions that could undermine affordability, stability, and choices for consumers. Key areas of concern include:

- **Flawed ESRD Payment Methods, Which Will Negatively Impact All MA Enrollees**: Payment methodologies in the Advance Notice do not adequately address expected costs from increased enrollment of Americans with ESRD. This increases the risk that seniors and others eligible for Medicare will face higher premiums, higher cost sharing, and/or reduced supplemental benefits.
- **Overall Payment Update Levels**: Because of certain CMS methodological assumptions and policies relating to benchmarks and risk adjustment, overall payment levels will not keep pace with expected increases in medical costs.

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

The Value of Medicare Advantage

MA plans deliver better care and better value through innovative, patient-centered programs that improve quality and reduce costs for seniors and others eligible for Medicare.

Greater care coordination and more comprehensive benefits. MA plans work with their members to prevent, detect, and manage chronic conditions through programs that better integrate and coordinate care compared to traditional Medicare. Plans also provide more comprehensive benefits than traditional Medicare (such as dental, hearing, and vision coverage) along with more extensive telehealth services and new types of benefits, such as nutrition, transportation, and in-home services that also help address various social barriers to better health.

More financial security. All MA plans cap enrollee annual out-of-pocket costs, while those with traditional Medicare coverage alone are exposed to extraordinarily high cost-sharing. Further, 93% of those eligible for Medicare have an option to enroll in an MA plan that offers drug coverage for no additional cost.[2]

[2] Medicare Payment Advisory Commission. Medicare Advantage program: Status report [presentation]. December 6, 2019.

Better health outcomes. Recent peer-reviewed research has found that MA plans have outperformed the traditional Medicare program on clinical quality measures[3], employed value-based payment arrangements to improve survival rates while lowering costs[4], reduced hospital readmissions as well as patient days spent in rehabilitation facilities and nursing homes[5,6], and lowered hospital use in the last days of life.[7]

Cost efficiency for seniors and taxpayers. For many years, average MA plan bids for delivering the basic Medicare benefit have been well below traditional Medicare costs—88% of traditional Medicare, based on the latest Medicare Payment Advisory Commission (MedPAC) estimates. Further, according to MedPAC, average payments to MA plans in 2020 are equivalent to traditional Medicare costs – and have been since 2017 – while offering supplemental benefits and enhanced financial security for seniors.[8] And in areas of the country where MA enrollment is higher relative to traditional Medicare, additional MA enrollment leads to slower traditional Medicare spending growth as providers employ MA practice patterns and care guidelines for their remaining traditional Medicare patients.[9]

High satisfaction. A recent survey finds continued high satisfaction with the MA program, with 93% of MA members reporting satisfaction with their health care coverage, 91% satisfied with their preventive services, and 88% satisfied with their prescription drug coverage. More than 90% of MA members would recommend it to their friends and family.[10]

Key Policy Concerns

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

Wholly inadequate changes in payment to address the expected increase in enrollment by people with ESRD. In combination, these proposals can increase program instability and result in higher premiums, higher cost sharing, and/or reduced supplemental benefits for all enrollees.

- **Insufficient changes to ESRD payment rates**: Currently, 25% of the more than 500,000 Medicare eligibles with ESRD are in MA plans. CMS projects ESRD enrollment to increase more than 30% in 2021, when MA enrollment restrictions are lifted under the 21st Century Cures Act – and enrollment rates could be even higher. We support proposals that CMS is separately considering that would give plans flexibility in dialysis facility networks to increase competition, drive down costs, and help plans

[3] 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.
[4] 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.
[5] 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.
[6] 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.
[7] 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.
[8] Medicare Payment Advisory Commission. Medicare Advantage program: Status report [presentation]. December 6, 2019.
[9] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.
[10] Morning Consult National Poll. December 10-17, 2019. Available online at: https://medicarechoices.org/americans-like-ma/

direct enrollees to higher-value care. However, we have serious concerns that CMS is not also proposing to change how it calculates payments for enrollees with ESRD despite analyses "suggesting that the payments derived from the current ESRD payment model fall well short of covering claim expenses."[11]

- **Cost increases affecting all MA enrollees**: CMS acknowledges the Advance Notice and Part C bidding instructions fail to account for the full degree of cost increases likely to affect the MA program due to out-of-pocket cost limit standards. This will negatively affect all MA enrollees by putting pressure on premiums, cost-sharing, and/or supplemental benefits.
- **Lack of transparency in exclusion of kidney transplant costs**: The Advance Notice does not provide transparency around substantial reductions in benchmarks for certain kidney transplant costs, with certain areas – particularly Puerto Rico – hit especially hard.
- **Recommended voluntary ESRD payment demonstration**: To address some of these concerns, AHIP recommends that CMS implement a voluntary ESRD payment demonstration to protect the MA program on a transitional basis while incentivizing further improvements in ESRD care.

Overall payment levels. CMS estimates that MA payments will increase, on average, by only 0.93% for 2021 with variable impacts in different areas. A recent study released by Wakely (see attached) indicates payments will likely be even lower after accounting for CMS' proposed adjustment to exclude certain kidney transplant costs, which will reduce overall payments by 0.43%.[12] This means average estimated 2021 payments levels, if finalized as proposed in the Advance Notice, would be well below expected growth in medical costs in the MA program. Plans are also concerned about costs related to the 2019-Novel Coronavirus (COVID-19) public health emergency for purposes of the bidding process.

Unstable growth rates. A major driver of MA payment levels is the projected fee-for-service (FFS) growth rate. We have significant concerns with this projection, including an almost 2 percentage point drop from preliminary estimates CMS released 2 months before the Advance Notice, and the lack of a meaningful and timely explanation for the change from the agency. We are also concerned about the large (nearly 2 percentage point) unexplained discrepancy between the FFS growth rate and the MA growth rate, the highest in at least 5 years. We request that CMS reexamine these estimates and be more transparent about the driving factors so stakeholders can adequately assess and explore methodological changes to enhance stability and predictability. We further urge CMS to address the annual volatility in ESRD growth rates.

Cuts in risk adjustment payments through "normalization." Another major driver of low estimated rates is a technical adjustment to risk scores known as "FFS normalization," which accounts for underlying changes in FFS enrollee health status over time to ensure MA plan bids and county benchmarks can be compared on the same basis. We continue to have significant questions and concerns about this annual adjustment, which CMS estimates will cause a 2.54% payment reduction in 2021. An analysis by Wakely found significantly lower risk score trends in the FFS data than CMS, and raises questions about the rationale offered by CMS for the large and continued year-over-year growth.[13] We

[11] The average MA plan medical loss ratio for beneficiaries with ESRD is 112%. See: Wakely Consulting Group. Increased ESRD beneficiary enrollment flexibility presents a potential financial challenge for Medicare Advantage plans in 2021. February 2019. Available online at: https://www.wakely.com/sites/default/files/files/content/increased-esrd-beneficiary-enrollment-flex-presents-potential-financial-challenge.pdf

[12] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

[13] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

ask CMS to provide more detail about the likely causes of this trend and publish analyses of potential methodological changes to minimize the issue, such as updating the model with more recent data.

Failure to adjust county benchmarks to include only people who are actually eligible to enroll in Medicare Advantage. AHIP continues to strongly support the recommendation of MedPAC that MA benchmarks only take into account individuals eligible for MA, i.e., those with *both Medicare Part A and B coverage*. CMS' decision to include people with Part A-only coverage artificially reduces rates in many counties.[14] Our recommended approach would align with the approach CMS is using under the new Direct Contracting (DC) payment model in the FFS program, which the agency acknowledges is being done "to ensure that the rates used for this model serve as an accurate representation" of costs.[15]

Ongoing CMS challenges relating to encounter data. CMS is proposing to increase the percentage of diagnoses from encounter data used in determining risk scores. We continue to be concerned with persistent CMS operational challenges involving encounter data. For example, the agency has acknowledged it has not correctly calculated payments based on encounter data for any year, starting with 2016 (when encounter data first began to be required for risk scores). CMS has also not released a detailed analysis of the completeness, accuracy, and reliability of the data. Now with 24 million enrollees and annual payments exceeding $233 billion in 2018, it is critical that CMS devote necessary resources to accurately calculate payments and address these issues. We also are concerned about the Administration's broader view of encounter data as a potential source of savings. For example, in addition to the fiscal year (FY) 2021 President's budget proposal noted below, CMS has not addressed concerns that encounter data filtering logic materially reduces risk scores.

Star Ratings proposals. Given that changes for the Star Ratings program are primarily made through the proposed rule, we will address those changes in more detail in our regulatory comments. However, we are concerned that the Star Ratings discussion in the Advance Notice, including measures that CMS is considering for future inclusion such as prior authorization and generic utilization, raises questions about CMS' commitment to ensuring Star Ratings measures reflect the fundamental goals and principles of the Star Ratings program as reflected in regulations.[16] We also ask CMS to consider a technical correction so the Part D Statin Use in Persons with Diabetes measure remains a 2021 process measure with a weight of 1. Also, we encourage CMS to engage with plans to consider expanding eligibility criteria under the disaster relief policy to cover more extreme and uncontrollable events (e.g., public health emergencies like COVID-19) that impact plan performance.

Future changes to the risk adjustment model. The President's budget proposal for FY 2021 includes a $40 billion cut to payments from recalibrating the risk adjustment model based on encounter data, effective 2024.[17] The Advance Notice does not mention this initiative. Yet, cuts to the MA program of that magnitude would have major implications for premiums and benefit packages that plans can offer seniors and people with disabilities. Given the complexity and impacts of such a proposed change, it is imperative that CMS share information and engage directly with plan sponsors far sooner and more extensively than the agency has done with respect to recent risk adjustment changes. CMS should have

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[14] For example, see: AHIP. Impacts of calculating MA payment rates excluding Part A only enrollees. Available online at: https://www.ahip.org/impacts-of-calculating-ma-payment-rates-excluding-part-a-only-enrollees/

[15] CMS. Direct Contracting Model: Global and Professional Options Request for Applications. November 25, 2019. Available online at: https://innovation.cms.gov/Files/x/dc-rfa.pdf

[16] The guiding principles call for, among other things, that measures be developed by consensus-based organizations; that Star Ratings be a true reflection of plan quality and enrollee experience; and that unintended consequences are minimized.

[17] HHS 2021 Budget in Brief. Available online at: https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf.

frequent and in-depth discussions with plan experts during the planning and development of a recalibrated model, including potential consideration of a budget neutrality adjustment during any transition to a new model. Further, given the complexity of such an undertaking, plans should have at least 2 years before the expected implementation date to review a fully proposed model, with a minimum 180-day comment period, so there is adequate time for meaningful analysis and comment.

The timing of CMS' rulemaking for 2021 has introduced significant uncertainty into the bid process. While historically released in the fall of the prior year, the proposed rule was not released until February 5 (the same day as the Advance Notice), with a comment deadline of April 6. Some proposals would have important impacts on the costs and/or benefits available to MA and Part D enrollees in 2021. We are concerned about CMS' ability to finalize the rule (and related sub-regulatory guidance) in time for plans to incorporate changes into projected costs or benefit designs for 2021 bids, which are due June 1. CMS should work with plans to identify and finalize proposals with significant impacts as quickly as possible separately from other parts of the proposed rule. More broadly, we ask CMS to recognize how the timing of its guidance can create an overall level of uncertainty for MA plans. An orderly bid development process and a predictable operating environment are critical to ensuring health insurance providers can invest in innovative programs and capabilities that benefit enrollees. We urge CMS to take these considerations into account in rulemaking and guidance roll-out processes.

Puerto Rico. We continue to be concerned about the large disparity in payment rates between Puerto Rico and the mainland. In the absence of policies that directly address this disparity, we welcome CMS' willingness to continue certain policies of importance to plans covering Medicare enrollees in Puerto Rico, such as basing rates on people who are enrolled in both Part A and Part B and granting certain counties eligibility for higher quality bonuses. We request that CMS continue its adjustment to reflect the larger proportion of FFS Medicare enrollees in Puerto Rico with zero claims compared to other parts of the United States.

Detailed Comments

Our attached comments cover a range of areas, including but not limited to the issues identified above. Our recommended changes are aimed at maintaining a strong and stable MA program that allows health insurance providers to continue working with others to improve American health care. The changes will ensure millions of seniors and people with disabilities continue to receive the high-quality, coordinated care they deserve, and rely on, through MA.

By working together, we can ensure that Medicare Advantage continues to be a leader in delivering affordability, access, choice, 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 Americans.

Sincerely,

Matthew Eyles

Matthew Eyles
President & Chief Executive Officer

Enclosure

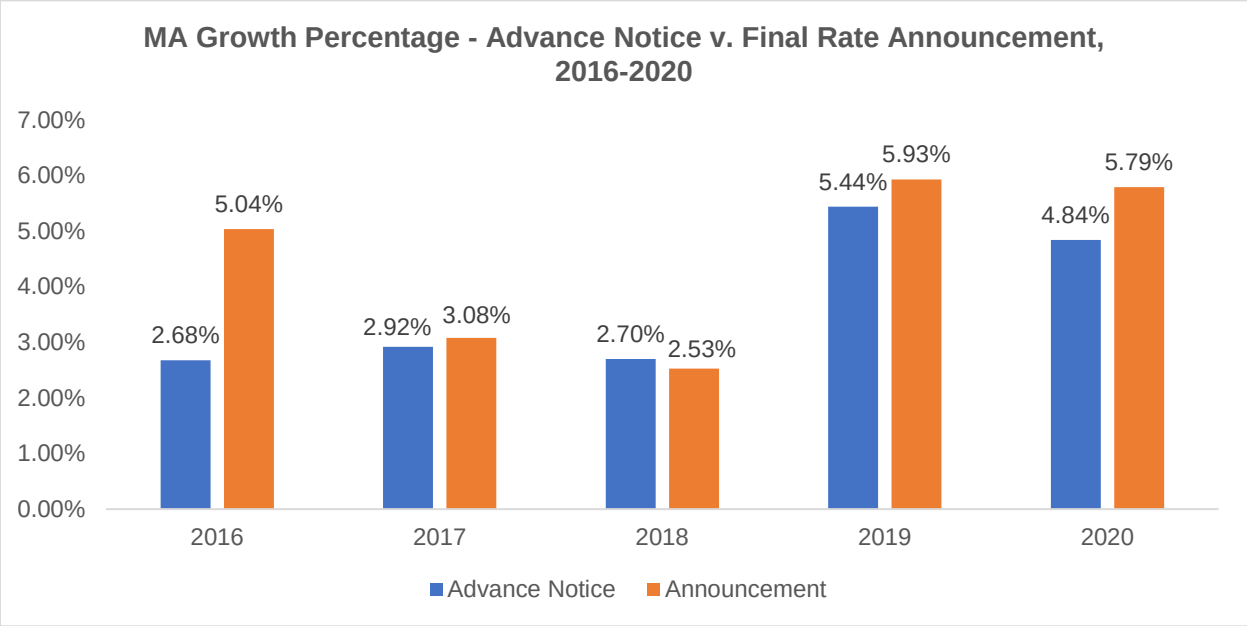
AHIP Detailed Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part I, CMS-HCC Risk Adjustment Model, and Part II

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2021

Section A. MA Growth Percentage (p. 6)

CMS estimates that the MA growth percentage for CY 2021 is 4.52%. This estimate is substantially lower than the Early Preview released on December 3 (5.28%).

With the exception of 2018, in the past five years a pattern has emerged in which the MA growth rate in the final Rate Announcement is higher than the preliminary estimate published in the Advance Notice. In 2018, negative corrections to prior estimates lead to a drop in the growth rate from the Advance Notice to the final Rate Announcement.



Recommendation: We request that CMS provide additional details about what drives these general trends and the exceptions to the trends. For example, is claims runout an explanation for why the earlier estimates are typically lower and therefore the Early Preview and Advance Notice lack the full claims experience due to timing issues? If so, why is the 2021 estimate in the Advance Notice lower than in the Early Preview? Are there other factors related to timing and data completeness that have a predictable impact on the growth rate estimates, such as annually updated enrollment projections? We also recommend CMS release key data elements underlying prior period restatements, including any enrollment, pricing, or utilization data that was updated in the current year's projection. At the same time, we request that CMS release in draft form, when both the Early Preview and the Advance Notice are released, the trends information that is released annually with the final Rate Announcement.[18] This

[18] For example, see: OACT. Key Components of United States Per Capita Cost (USPCC) Trends for 2016-2020. Available online at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Narrative-2020-Payment-Notice.pdf

information will reduce uncertainty and improve the bidding process by allowing plans to develop more accurate projections.

Section B. FFS Growth Percentage (pp. 6-7)

FFS USPCC – Non-ESRD. As noted above, CMS estimates that the FFS growth percentage for CY 2021 is 2.57%. This estimate was revised downward by nearly 2 percentage points from the December 3 Early Preview (4.46%). On the February 7 stakeholder call and the February 20 Actuarial User Group call, OACT explained that the reduction was driven by updates to historical claims and enrollment data, including:

- A -0.8 percentage point impact due to revised 2017 and 2018 enrollment data;
- A -0.7 percentage point impact due to restatements of pre-2017 incurred claims resulting from re-allocation of Part A home health spending from non-end-stage renal disease (ESRD) to ESRD beneficiaries, revisions to tabulation of incurred bad debt expenditures, improvements in modeling of incurred claims for Part A buy-in beneficiaries, and re-mapping of some Part B services to new benefit categories; and
- Emerging claim experience for 2018 and 2019 and revisions to 2020 projection factors.[19]

Based on the explanation, we have several concerns with this adjustment. As a technical and operational matter, it is not clear why the updates to historical (pre-2017) claims and (2017 and 2018) enrollment data were not included in the Early Preview. That data would appear to have been available to CMS at the time of the Early Preview estimate. While we commend CMS for publishing the Early Preview, the analysis is less useful for planning purposes when such data is excluded.

In addition, we have serious concerns that CMS' practice of restating prior year spending in order to determine future year growth rates creates material uncertainty for MA plans in developing business plans and forecasting trends several years into the future. Such fluctuations increase the administrative burden on plans to develop stable benefit packages for existing products as well as in offering new benefits or expanding into new service areas.

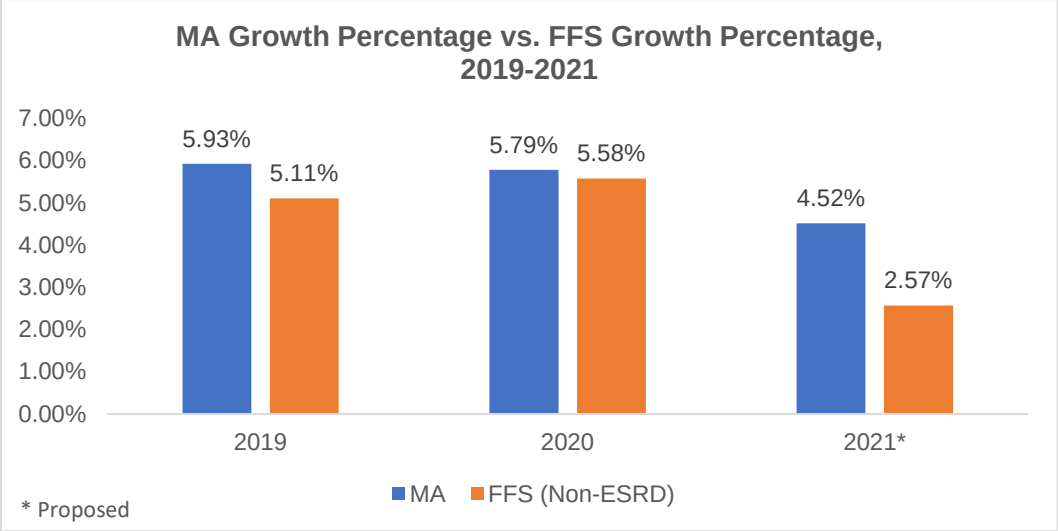
Recommendation: We request more information from CMS about these components of the CY 2021 Early Preview and Advance Notice estimates. Consistent with our recommendation above on the MA growth percentage, CMS should release more detailed support for the FFS USPCC and growth trends with the Early Preview and Advance Notice, similar to the annual memo released by CMS with the final Rate Announcement.[20] Going forward, we also urge CMS to use more complete claims experience and other data as well as to make appropriate adjustments in advance of the Early Preview to the greatest extent possible. When prior restatements do occur, CMS should release the underlying enrollment, price, and utilization data elements and methodology used in the calculations leading to the restatement. CMS should also take steps to improve the accuracy of the FFS growth percentage and the stability of the MA program for beneficiaries by minimizing the impact of prior year restatements in the growth rate methodology. We also request that CMS issue clear and timely guidance on costs related to the 2019-Novel Coronavirus (COVID-19) public health emergency for purposes of the bidding process.

Comparison to MA growth percentage. We have significant questions about why the MA growth percentage (4.52%) is nearly two times larger than the FFS growth percentage estimated in the Advance

[19] See User Group Call Data 02/20/2020. Available online at: https://www.cms.gov/files/document/cy-2021-actuarial-bid-questions.pdf-1

[20] For example, see: OACT. Key Components of United States Per Capita Cost (USPCC) Trends for 2016-2020. Available online at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Narrative-2020-Payment-Notice.pdf

Notice (2.57%). CMS has not released any information to explain how these two growth rate estimates have diverged so drastically. The difference between the MA and FFS growth percentages is much larger than in 2019 and 2020.



As the MA growth percentage represents both MA and FFS trends, and the majority of Medicare beneficiaries remain in the FFS program, it is unclear how the MA growth rate could be so much higher than the FFS growth rate. According to a recent analysis by Wakely Consulting Group (Wakely), the MA growth percentage estimated by CMS implies an MA-specific payment rate change of over 8.4% – it is unclear what components of MA payment could account for such a significant increase year over year.[21] This divergence raises concerns about the accuracy of the relative estimates.

Recommendation: We urge CMS to specifically address this issue in the final Rate Announcement. The final Rate Announcement should include additional information to explain diverging trends between the MA and FFS growth percentages, including a detailed breakdown of the major factors contributing to both growth percentages (e.g., demographics, case mix, price versus utilization) and the underlying data used to estimate these breakdowns. This information will allow for better understanding and validation of the CMS estimates by stakeholders as well as to help improve the bidding process through reducing uncertainty.

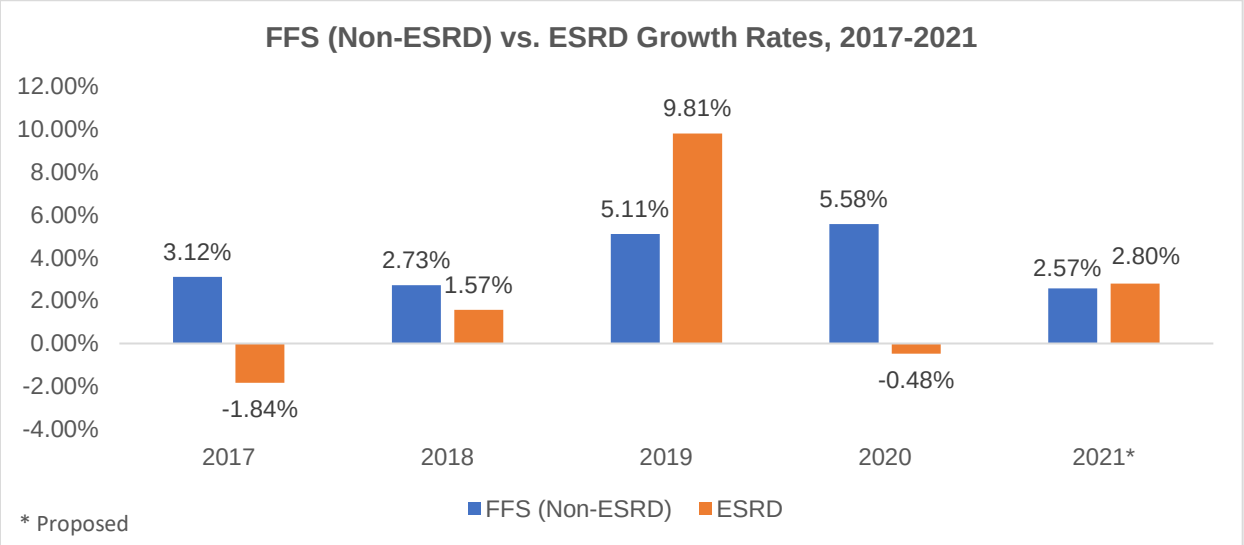
Impact of CAR T-cell therapy. We are concerned that CMS may not have fully accounted for the cost of Chimeric Antigen Receptor (CAR) T-cell therapy for cancer in the development of FFS United States Per Capita Cost (USPCC). According to the National Coverage Determination (NCD) CMS issued on August 7, 2019, CAR T-cell therapy for cancer obtained by MA enrollees will be paid by the FFS Medicare program in 2019 and 2020 because the service is considered a "significant cost" under Section 422.109(a)(2) of title 42 of the Code of Federal Regulations. The memo indicates that MA plans should account for CAR T-cell therapy for cancer items and services in 2021 bids. However, the Advance Notice does not indicate how CAR T-cell therapy costs have been accounted for in the development of the FFS USPCC.

Recommendation: We recommend that CMS clarify whether the 2021 FFS USPCC incorporates the expected cost of CAR T-cell therapy for cancer. If not, CMS should make an adjustment to its

[21] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

methodology based on costs incurred by the FFS Medicare program in 2019 and 2020. CMS made a similar adjustment to account for a NCD of significant cost in 2019.[22]

Dialysis-only ESRD USPCC. CMS estimates the ESRD growth percentage for CY2021 is 2.80%, a slight decrease from 2.91% estimated in the Early Preview. Over the past five years, there has been significant volatility in the ESRD growth rate year-to-year and particularly in comparison to the FFS growth rate.



CMS has not explained why the ESRD growth rate trends are often inconsistent with and much more volatile than the FFS growth rate trends.

Recommendation: We request that CMS provide detailed information – consistent with the types of information requested above in relation to the MA and FFS growth percentages – that addresses the historic volatility of the ESRD growth rate over time. We also recommend that CMS modify its methodology to minimize the volatility. For example, using five years of historical FFS claims data (rather than one year, as is current practice) to calculate the ESRD growth percentage would more closely align the methodology with the FFS growth percentage. We believe using five years of historical claims data in this manner will reduce the year to year volatility in the ESRD growth rate that we observe from 2017 to 2021.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2021

Section B. Calculation of Fee for Service Cost

B1. AGA Methodology (pp. 17-22). Consistent with prior years, CMS proposes several changes to the calculation of the average geographic adjustments (AGAs) used to determine the county benchmarks. CMS indicates that these changes are primarily associated with adjusting the FFS claims data for shared savings and losses of alternative payment models, including accountable care organizations, bundled payment demonstrations, and other CMS Innovation Center (Innovation Center) payment models. CMS proposes to limit the adjustment for Innovation Center models to the 16 models listed in Table B1-1 of

[22] In the 2019 Advance Notice, OACT made an adjustment to its projection of the FFS USPCC to account for a NCD requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD). The cost of SET for PAD was covered by FFS Medicare in 2017 and 2018, and plans were required to account for these items and services in bids for 2019.

the Advance Notice. CMS further proposes to continue excluding other models, as well as payments under the 16 models – such as care management fees – that are funded through the Innovation Center rather than the Medicare Part A or B Trust Funds.

We are concerned that CMS is limiting its adjustment of the AGAs for Innovation Center demonstrations and payment models to the 16 listed in Table B1-1. The Innovation Center has tested over 80 models, the vast majority of which impact FFS Medicare. In addition, elements of the 16 models that CMS is excluding can be substantial: for example, in the Comprehensive Primary Care Plus (CPC+) program the median 2017 per practice care management fees were $88,003 for Track 1 and $195,469 for Track 2.[23] We are not aware of any statutory basis for excluding these costs from the calculation of MA benchmarks. Similar to CMS' policy (discussed below) of including certain enrollees ineligible for MA in calculating benchmarks, the exclusion of these funds means CMS is not determining the cost of providing a benefit to MA enrollees that is comparable to what it would be if the benefit were provided to such enrollees under the FFS program. This should be the key test in setting MA benchmarks, not the source of FFS funding.

Recommendation: We recommend that CMS reconsider its policy of excluding models in its adjustment of the AGAs to the extent the models involve payments such as bonuses and care management fees funded through the Innovation Center. Instead, CMS should apply the "actual spending impact" of any demonstrations and payment models in its adjustment of the AGAs, including care management fees and other spending amounts not reflected in shared savings/losses.

Additionally, on pages 21-22 CMS notes that it will standardize the county benchmarks using "the county's average five-year risk score from the risk adjustment model used for contract year (2021) payment." For 2021, CMS is proposing to use a blend of the 2020 CMS-HCC model at 75% and the 2017 CMS-HCC model at 25%. It is not clear whether CMS is proposing to standardize the benchmarks using risk scores calculated via this blend.

Recommendation: We request that CMS clarify how it intends to risk adjust the AGAs in the final Rate Announcement.

B2. Additional Adjustment to FFS per Capita Costs in Puerto Rico (pp. 22-23). The MA program is critically important in Puerto Rico. More than two-thirds of Medicare beneficiaries in Puerto Rico are enrolled in MA plans (69% as of February 2020). A substantial number 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. This situation could be exacerbated by the kidney acquisition cost carve-out, discussed in more detail below, which will significantly reduce benchmark rates in Puerto Rico relative to the mainland.

The Secretary has previously directed OACT to account for the fact that a higher proportion of beneficiaries in Puerto Rico did not have claims than beneficiaries outside of Puerto Rico. As CMS noted in the 2021 Advance Notice, the agency determined that 14.9% of Puerto Rico beneficiaries enrolled in both Medicare Parts A and B had no claims, as compared to 6.1% of beneficiaries nationwide during the

[23] Mathematica Policy Research. Independent Evaluation of Comprehensive Primary Care Plus (CPC+) First Annual Report. April 2019. Available online at: https://downloads.cms.gov/files/cmmi/cpcplus-first-ann-rpt.pdf

period 2013 to 2017. OACT applied this adjustment in the 2020 rates, and OACT is considering whether to make this adjustment for the 2021 rates.

CMS also notes on page 18 that it will continue to adjust the FFS calculation for Puerto Rico to include only those beneficiaries enrolled in both Parts A and B. 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.

Recommendation: 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. In the absence of a such a policy change, 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 and we strongly encourage the agency to continue making this adjustment. We support CMS in continuing to include these counties in Puerto Rico when determining which counties qualify for the double bonus payment in CY 2021. AHIP also supports CMS continuing to adjust the calculation of benchmarks for Puerto Rico using only claims data for beneficiaries enrolled in both Parts A and B (note: we recommend this adjustment be made to the calculation of all county benchmarks, described in more detail below).

B4. Organ Acquisition Costs for Kidney Transplants (pp. 24-26). Pursuant to Section 17006(b) of the 21st Century Cures Act (Cures Act), CMS developed a methodology to exclude the cost of organ acquisition for kidney transplant from the MA benchmarks beginning in 2021, when these costs must be covered by the FFS Medicare program. In its methodology, CMS used Medicare cost report data and FFS inpatient claims data to calculate kidney acquisition costs as a percent of total FFS costs at the county and state levels, and then applied these ratios to carve-out kidney acquisition costs from the MA county and state ESRD benchmarks.

We are concerned with the magnitude of the organ acquisition cost carve-out factors. CMS estimates that the average impact would be $4 PMPM for MA county rates, up to a high of $20 PMPM. Separately, the average impact would be $36 PMPM for state ESRD rates, up to a high of $75 PMPM. The carve-out ratios are particularly large across Puerto Rico (up to 4.29%), as well as in counties including Madison, WI (1.85%); San Francisco, CA (1.66%); New Orleans, LA (1.66%); St. Louis, MO (1.64%); San Antonio, TX (1.30%); and Winston-Salem, NC (1.28%).

These CMS estimates from the 2021 Advance Notice appear to diverge from the estimates included in the separate MA and Part D Proposed Rule for 2021 and 2022 that addresses the same provisions of the Cures Act. Specifically, in the Proposed Rule CMS estimates the FFS Medicare cost of kidney acquisition at $2.82 PMPM in 2021.[24]

To test the validity of CMS' estimates, Wakely analyzed a 5% sample of FFS Medicare claims data from the Limited Data Set (LDS) over the period 2014 to 2018.[25] These data suggest there were only a total of 11,340 kidney transplants for FFS Medicare beneficiaries in 2017 – this figure is 26% lower than the estimate of 15,436 CMS provided in the Proposed Rule. Wakely also found that only 20 of the 82

[24] See Table 29 on page 9184. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Fed Reg Vol. 85 No. 32, 9002-9260. Available online at: https://www.regulations.gov/document?D=CMS-2020-0010-0002

[25] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

counties with a kidney acquisition carve-out rate above 1.0% had *any* kidney transplants identifiable in the LDS claims data. This analysis for the top 10 counties by kidney acquisition carve-out rate, excluding Puerto Rico, is shown below.

State	County	Kidney Acquisition Cost Carve-Out Factor in Advance Notice	Total Kidney Transplants (2014-2018 LDS)
OREGON	COLUMBIA	2.79%	0
WISCONSIN	DANE	1.85%	6
LOUISIANA	PLAQUEMINES	1.85%	0
CALIFORNIA	SAN FRANCISCO	1.66%	3
LOUISIANA	ORLEANS	1.66%	7
MISSOURI	ST LOUIS CITY	1.64%	6
NORTH CAROLINA	ORANGE	1.60%	0
MINNESOTA	OLMSTED	1.52%	1
PENNSYLVANIA	MONTOUR	1.44%	1
MINNESOTA	DODGE	1.35%	0

Recommendation: We request that CMS release additional information to allow for validation of the underlying cost and discharge data used to calculate the kidney acquisition costs in determining the carve-out factors, and explain why the estimates derived in the Proposed Rule differ from those presented in the Advance Notice.

In addition, we believe this change to the benchmark calculation should have been included in the impact analysis that was part of the Fact Sheet CMS released with the Advance Notice. Wakely estimates that the impact of this change, based on the kidney acquisition cost carve-out factors CMS released with the Advance Notice and January 2020 enrollment, will be a reduction in MA payments of 0.43%.[26]

Recommendation: In the Fact Sheet that will be released with the final Rate Announcement, CMS should include this change to the benchmarks in its bottom-line impact analysis.

Finally, we are concerned that the removal of kidney acquisition costs from the benchmark rates could have unintended consequences for the calibration of the risk adjustment model, as the risk adjustment models were not updated for 2021 to reflect such a change.

Recommendation: We request that CMS comment on whether the agency determined if the removal of these costs from the benchmark may impact the accuracy of the ESRD risk adjustment models and release any related data and analyses.

Section D. ESRD Rates (pp. 26-28). In response to the 2020 Advance Notice, many commenters raised concerns about the adequacy of the state ESRD benchmarks and volatility in the ESRD growth rate from year to year, particularly in light of the Cures Act provision allowing beneficiaries with ESRD to enroll in MA plans beginning in 2021. CMS responded to these concerns as follows: "We appreciate the concerns commenters have raised. We will continue to analyze these issues and consider whether, consistent with

[26] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years."

In the 2021 Advance Notice, CMS proposes to use the same methodology to calculate state ESRD benchmark rates as in 2020 but updated with more recent historical claims data. CMS does not include in the Advance Notice any discussion of analyses conducted by the agency concerning the adequacy of the ESRD benchmark rates, the volatility of the growth rate, or any other issues raised in response to the 2020 Advance Notice. The only process change CMS is proposing for 2021 will be to release a file with the final Rate Announcement including key components of the rate development comparable to the data files CMS releases for non-ESRD county benchmark rates.

We appreciate the additional transparency on ESRD rate development CMS will be providing with the final Rate Announcement. However, we have three serious concerns with the ESRD rate methodology: (1) the overall inadequacy of the benchmarks, (2) the impact of the annual limit on beneficiary out-of-pocket spending, and (3) widespread geographic variation in spending for beneficiaries with ESRD.

Overall Inadequacy of Benchmarks

Beneficiaries with ESRD represent less than 1% of the total Medicare population but 7% of spending.[27] Using the USPCC published in the 2021 Advance Notice, annual FFS Medicare spending on beneficiaries with ESRD is estimated to be $96,162 compared to $11,580 for non-ESRD beneficiaries. Despite the significantly higher benchmark rates, Wakely estimates that under current rules, the average MA plan has a medical loss ratio (MLR) well above 100%, and 27 percentage points higher than the MLR for non-ESRD beneficiaries.[28]

According to Wakely, if every Medicare beneficiary with ESRD were to enroll in an MA plan, on average premiums would need to increase by an estimated $18 PMPM (an increase of more than 75%[29]) – or benefits would need to decrease by the same magnitude – at current MLR levels. Each increase in ESRD beneficiary penetration in the MA program of 0.46% would increase premiums on average by $4.60 PMPM, all else equal.

ESRD % of Total MA Enrollment	Premium Increase at Current MLR
0.67%	$0.00
1.13%	$4.63
1.59%	$9.18
2.05%	$13.78
2.51%	$18.43

One important, contributing factor is the highly concentrated dialysis provider market, which leverages network adequacy requirements to demand favorable contracting terms from MA plans for dialysis

[27] Avalere. Medicare Advantage plans may be paid below actual ESRD patients' costs in large metropolitan areas in 2021. December 2019. Available online at: https://avalere.com/insights/medicare-advantage-plans-may-be-paid-below-actual-esrd-patients-costs-in-large-metropolitan-areas-in-2021
[28] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/
[29] CMS estimates the average MA premium in 2020 will be $23. See: https://www.cms.gov/newsroom/press-releases/trump-administration-drives-down-medicare-advantage-and-part-d-premiums-seniors

services.[30] This can result in MA plans incurring costs for dialysis services well above FFS Medicare rates.[31] The other factor relates to the maximum out-of-pocket (MOOP) limit.

Impact of the MOOP Limit

Current regulations require that MA plans limit the out-of-pocket costs of all their members, regardless of ESRD status. In 2020, the mandatory MOOP limit is $6,700 for in-network services, though many plans offer more generous benefit packages with a lower MOOP amount.

Due to high overall spending, out-of-pocket costs for beneficiaries with ESRD in FFS Medicare are significantly higher than for non-ESRD beneficiaries. A recent analysis by Health Management Associates (HMA) found that the average ESRD beneficiary in FFS Medicare incurs $13,000 in out-of-pocket costs, which is significantly higher than the MOOP limit.[32] Wakely estimates that 79% of beneficiaries with ESRD in FFS Medicare incurred annual out-of-pocket costs exceeding $6,700 in 2018.[33]

CMS is well-aware of the impact ESRD beneficiary spending could have on MA plan premiums and supplemental benefits. In the 2021 Part C Bidding Instructions memorandum, CMS acknowledges how greater MA plan subsidization of ESRD beneficiary spending could impact all MA enrollees if not properly addressed:

> *As beneficiaries with diagnoses of ESRD enroll in MA plans and incur greater costs, MA plans will have to cover higher costs when ESRD enrollees meet the MOOP limit and incur more costs past the MOOP threshold than non-ESRD enrollees are projected to do. In covering higher costs, MA plans would likely have to increase premiums to all enrollees or would not be able to continue to offer viable benefit designs.*

In its Part C Bidding Instructions, CMS has proposed to increase the MOOP limit by incorporating the historical FFS Medicare spending of beneficiaries with ESRD into the methodology. However, analyses by Wakely show this proposed policy change would be insufficient to address the substantial inadequacy of the ESRD rates. Wakely found, when looking at costs for beneficiaries with ESRD in FFS Medicare, that imposing a $6,700 MOOP raises program costs by 9.2% relative to no MOOP. Furthermore, increasing the MOOP by $850 to $7,550, as CMS has proposed for 2021, would only lower these increased program costs by 1 percentage point. The increased costs to the Medicare program from applying a $7,550 MOOP would still be 8.2%.

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[30] Two companies own over 70% of all dialysis centers. See: Milliman. Medicare Advantage: Eight critical considerations for every organization as ESRD eligibility expands in 2021. December 2019. Available online at: https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicare-advantage-eight-critical-considerations.ashx

[31] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

[32] Health Management Associates. End-stage renal disease and Medicare Advantage. February 2020. Available online at: https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf

[33] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

Measure	Population	MOOP Level None	$3,450	$6,700	$7,550
Estimated LDS Paid PMPM	Non-ESRD	$831	$877	$855	$852
	ESRD	$7,221	$8,173	$7,883	$7,813
% Change vs. No MOOP	Non-ESRD		5.5%	2.9%	2.5%
	ESRD		13.2%	9.2%	8.2%

HMA similarly found that applying the MOOP increases Medicare program costs by 8 to 9% on average for beneficiaries with ESRD.[34] While CMS' proposal to increase the mandatory MOOP to $7,550 will reduce program costs to some degree, this change in the MA benefit parameters could lead to greater out-of-pocket costs for all MA enrollees, not just those with ESRD, and will not address the lack of adequate funding for this population.

Geographic Variation in ESRD Spending

CMS currently determines ESRD benchmarks at the state level. However, within any given state there is significant variation in FFS Medicare spending by beneficiaries with ESRD across local areas. According to HMA, in 2017 average FFS Medicare costs in Oakland were 113% of the state average while costs in San Diego were 89% of the state average.[35] Similar results were found across metropolitan areas in Florida, Ohio, and Texas, suggesting the state ESRD benchmarks do not adequately reflect the costs of serving beneficiaries with ESRD in many areas. Analyses by Avalere found that in 10 of the 15 largest metropolitan areas by ESRD enrollment, FFS Medicare costs exceed the MA payment rate.[36]

Consistent with these analyses, Wakely found that in the top 15 counties by MA enrollment, 11 counties had a cost to payment ratio over 100% for beneficiaries with ESRD. This ratio was as high as 136.5% in Kings County, NY (i.e., Brooklyn), meaning that FFS Medicare costs for ESRD beneficiaries living in Brooklyn were 36.5% higher than the New York state ESRD benchmark rate that an MA plan serving this population would be paid.

State	County	January 2020 MA Enrollment	January 2020 MA Penetration Rate	2018 ESRD Dialysis Cost/Payment
CA	Los Angeles	1,603,769	48.3%	114.4%
FL	Miami-Dade	503,439	66.7%	114.9%
AZ	Maricopa	762,339	42.0%	101.9%
TX	Harris	599,681	46.2%	118.4%
CA	Orange	549,680	48.7%	92.6%
CA	San Diego	575,361	46.0%	93.4%
IL	Cook	882,163	29.9%	121.9%

[34] Health Management Associates. End-stage renal disease and Medicare Advantage. February 2020. Available online at: https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf
[35] Health Management Associates. End-stage renal disease and Medicare Advantage. February 2020. Available online at: https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf
[36] Avalere. Medicare Advantage plans may be paid below actual ESRD patients' costs in large metropolitan areas in 2021. December 2019. Available online at: https://avalere.com/insights/medicare-advantage-plans-may-be-paid-below-actual-esrd-patients-costs-in-large-metropolitan-areas-in-2021

State	County	January 2020 MA Enrollment	January 2020 MA Penetration Rate	2018 ESRD Dialysis Cost/Payment
CA	Riverside	421,808	53.3%	93.5%
FL	Broward	363,232	52.7%	123.6%
CA	San Bernardino	333,539	55.7%	123.5%
NY	Queens	398,172	45.9%	127.0%
NY	Kings	407,537	43.0%	136.5%
PA	Allegheny	279,175	60.0%	110.2%
NV	Clark	398,628	41.4%	97.2%
MI	Wayne	354,164	45.9%	114.5%

Payment Demonstration

A large influx of beneficiaries with ESRD into the MA program could put upward pressure on premiums or lead to reductions in supplemental benefits without major policy changes. While we generally support CMS' proposals to incorporate historical spending by beneficiaries with ESRD into the calculations that set annual out-of-pocket spending limits (see our comments on the Part C Bidding Instructions below), these proposals will only shift additional costs to beneficiaries and do not address the underlying issues of payment adequacy for this population.

Recommendation: For 2021, in the event CMS does not increase benchmarks to address the concerns raised above, we recommend that CMS implement a transitional demonstration for MA plans that temporarily increases plan payments for ESRD beneficiaries to fund the implementation of interventions designed to reduce total cost of care for this population.[37] For example, under the demonstration MA plans could be paid using a cost-based reimbursement formula with shared savings if actual costs are less than a target benchmark. Upfront investment in the MA program through a demonstration will allow plans to better prevent the progression of chronic kidney disease, increase quality of care by dialysis providers, increase quality of life for beneficiaries, and potentially reduce program costs.

The demonstration should be voluntary and national in scope to allow any interested MA plan to participate, depending on the unique circumstances of its service area and population. To be eligible for the increased capitation rate, an MA plan would be required to meet certain pre-specified metrics, e.g., implementing processes designed to: increase – where clinically appropriate – rates of kidney transplant and the delivery of dialysis and related services in non-facilities settings (such as the home or physician office), similar to the payment methodology being developed for the ESRD Treatment Choices model in FFS Medicare; reduce the rate at which people progress to higher stages of chronic kidney disease; or increase value-based arrangements relating to kidney care.

The Administration has expressed significant interest in addressing kidney disease through a recent Executive Order, the KidneyX partnership, and a range of payment models in FFS Medicare. However, MA plans are excluded from participating in the current ESRD payment models. The demonstration we propose is necessary to promote the same goals for advancing kidney care within the MA program as in FFS Medicare, and will provide a glidepath for MA plans to transform the delivery of kidney care in the

[37] There is precedent for CMS developing a demonstration after release of the Advance Notice and prior to bid submission to address programmatic payment concerns. Just last year, CMS proposed a demonstration that would have narrowed Part D plan risk corridors the following payment year in anticipation of finalizing a proposed rule that would have affected Part D rebates.

MA program while simultaneously absorbing increased enrollment by beneficiaries with ESRD in lieu of immediate changes to the benchmarks.

The Cures Act requires that the Secretary submit a report to Congress no later than December 31, 2023 that includes an analysis of enrollment and spending for beneficiaries with ESRD across the FFS and MA programs, as well as the "the sufficiency of the amount of data" under FFS Medicare "for purposes of determining payment rates" for ESRD beneficiaries in MA. We therefore recommend this demonstration be in effect through 2024, after which time CMS will be able to make better-informed decisions regarding the impact of ESRD enrollment in MA and the calculation of ESRD rates based upon the report to Congress.

In its separate Proposed Rule, CMS is considering changes to network adequacy requirements for dialysis providers that would allow plans greater flexibility to develop provider networks to deliver dialysis services, including greater use of home dialysis. These flexibilities will allow for greater competition in the dialysis market and promote innovate new ways to serve beneficiaries with ESRD that require dialysis services. We strongly support more flexibility and will provide detailed comments on or before the comment deadline for the Proposed Rule. However, at this time we want to highlight that to the extent CMS finalizes such proposals allowing MA plans greater flexibility to meet network adequacy requirements for dialysis providers beginning in 2021 *and* these flexibilities are found to lower costs for dialysis services through rapid cycle evaluation, this demonstration could be modified during the period of performance.

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

For several years we have raised concerns that CMS is not appropriately calculating all MA benchmarks from an actuarial perspective, as the current methodology includes beneficiaries who are not eligible to enroll in MA. A Medicare beneficiary must have both Part A and Part B to be eligible for MA plan enrollment, yet CMS calculates the rate based on enrollees with either Part A or Part B. Actuarial principles require that an estimate of the benchmark must represent what that enrollee would cost in FFS Medicare. By using claims experience from FFS Medicare beneficiaries who are not eligible to enroll in MA, CMS is calculating benchmarks that include beneficiaries with only Part A and only Part B, and therefore does not appropriately estimate what would have been paid for the same beneficiary had they remained in FFS Medicare. CMS has made this adjustment to the benchmark rates for Puerto Rico since 2012.

2020 Final Notice

In the 2020 Final Notice, CMS described a wide range of concerns raised by commenters in response to the 2020 Advance Notice regarding this issue, including: increasing rates of Part A-only beneficiaries; the higher spending patterns of beneficiaries with both Parts A and B in comparison to beneficiaries with Part A only; the positive correlation between MA penetration rates and rates of Part A only beneficiaries; various quantitative analyses estimating a significant impact on benchmark rates from making such an adjustment; and acknowledgement that CMS currently makes this adjustment to benchmarks for Puerto Rico. However, CMS did not respond substantively to any of the actuarial concerns raised; instead, CMS offered a legal argument that it has the authority and discretion to calculate the benchmarks in this manner under the statute:

> *We do not believe that it is necessary or required to change the methodology at this time, however. We note that section 1853(c)(1)(D) requires that the estimate be 'for individuals who are not enrolled in an MA plan' for the applicable area for the year. This language clearly permits CMS to include Medicare beneficiaries who have Part A or Part B only.*

With regard to the appropriateness of the methodology, CMS responded, "we believe that our current methodology is well within the latitude provided in the statute for how the estimate is developed" and that "we remain convinced that the methodology is sound and within the agency's discretion." However, CMS provided no analyses to demonstrate what has convinced the agency that the methodology is sound given the serious concerns raised by commenters. We believe CMS has a responsibility to support its belief with empirical analyses demonstrating that the methodology is sound, not just assert that the agency is acting with its discretion.

For the third consecutive year, CMS stated in the 2020 Rate Announcement "we will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years" and yet no mention of these analyses was included in the 2021 Advance Notice.

Recommendation: We continue to believe that CMS, based on a plain reading of the statutory language and the application of actuarial principles, should base MA benchmarks only on the FFS Medicare claims cost of beneficiaries eligible for enrollment in MA (those beneficiaries eligible for both Medicare Part A and Part B). We urge CMS to publicly release its analyses regarding this issue to demonstrate how the methodology can be sound given the material difference between the population enrolled in MA and the FFS Medicare population used to determine benchmarks.

VA/DoD Adjustment

CMS currently makes, and has been making for several years, adjustments to per capita FFS costs for Medicare beneficiaries who are dually eligible for health care benefits through the Department of Veterans Affairs (VA) or Department of Defense (DoD). CMS has found that including these beneficiaries in the calculation without an adjustment biases claims cost downward because a material portion of health care spending on Medicare-covered services for these beneficiaries is covered by a payer other than Medicare, unlike the majority of Medicare beneficiaries.

In the 2017 Advance Notice, CMS provided a high-level impact analysis of making an adjustment for VA dual-benefit eligibles. In its analysis, CMS found that for the average base county rate (0% QBP), 67% of counties would see an increase in their rates and that the overall average impact would be an increase of approximately $5. In AHIP's analysis[38] of the impact of adjusting benchmarks to account for beneficiaries with both Medicare Parts A and B, 94.4% of counties representing 98.4% of MA enrollment would see an increase in benchmark rates. Of these, 45% of counties representing 61% of MA enrollment would see an increase of not $5 but *5%* or more.

Recommendation: We request that CMS explain why an adjustment is made for VA/DoD dual-benefit eligibles but not for Medicare beneficiaries with Part A only or Part B only.

Direct Contracting Model

In the Request for Applications to the Direct Contracting model, the Innovation Center states that it "will make adjustments to account for differences between the subset of FFS beneficiaries eligible," including an adjustment because "aligned beneficiaries must be enrolled in both Medicare Parts A and B."[39] Thus, the Innovation Center has determined that it is appropriate to base Direct Contracting model payments on the experience of beneficiaries with both Parts A and B because of eligibility requirements for participating in the model. We see no basis for why CMS should refuse a similar adjustment for the MA

[38] Available online at: https://www.ahip.org/impacts-of-calculating-ma-payment-rates-excluding-part-a-only-enrollees/
[39] CMS. Direct Contracting Model: Global and Professional Options Request for Applications. November 25, 2019. Available online at: https://innovation.cms.gov/Files/x/dc-rfa.pdf

program. Wakely has noted that it is "actuarially inconsistent" to make this adjustment for Direct Contracting Entities but not modify the MA benchmarks.[40]

Recommendation: We urge CMS to explain the distinction between the Direct Contracting model and MA methodologies, including an impact analysis of making this adjustment in the Direct Contracting model compared to the MA benchmarks.

Section G. CMS-HCC Risk Adjustment Model for CY 2021 (p. 32)

On January 6, 2020, CMS published Part I of the Advance Notice, which includes proposed changes to the CMS Hierarchical Condition Category (HCC) risk adjustment model for 2021. In 2020, CMS implemented a new risk adjustment model that added condition count variables that would increase the risk score if a person has at least four HCCs, in accordance with the requirements of the Cures Act, and added three new HCCs for dementia and pressure ulcers (the 2020 CMS-HCC model). In 2020, this model represents 50% of the risk score; the remaining 50% of the risk score is calculated using the 2017 CMS-HCC model.

For 2021, CMS is proposing to increase the blend of the 2020 CMS-HCC model from 50% to 75% and reduce the blend of the 2017 CMS-HCC model from 50% to 25%. This continued phase-in of the new risk adjustment model is consistent with the statutory requirement of the Cures Act that the new model be fully phased-in by 2022.

As in 2020, CMS is proposing to base the 2020 CMS-HCC model risk score on diagnoses from the encounter data system (EDS), supplemented with inpatient diagnoses from the Risk Adjustment Processing System (RAPS), and base the 2017 CMS-HCC model risk score on diagnoses from RAPS only. As we note in our comments below, we continue to have concerns with persistent operational issues in the use of encounter data and urge CMS to address these issues immediately to reduce additional administrative burden on MA plans and providers.

Section J. Medicare Advantage Coding Pattern Adjustment (p. 34)

The Advance Notice announces that for CY 2021, CMS is proposing to apply the statutory minimum MA coding adjustment factor of 5.90%.

Recommendation: AHIP supports the agency's decision to maintain and not exceed the statutory minimum adjustment level.

Section K. Normalization Factors

CMS-HCC Model Normalization Factor (pp. 36-39). CMS proposes a normalization factor of 1.106 for the 2017 CMS-HCC model and 1.097 for the 2020 CMS-HCC model, which would result in an estimated 2.54% reduction to MA plan payments from 2020. CMS proposes to use risk score data from 2015 to 2019 to estimate the normalization factors, which would reflect six years of trend between the denominator year and the payment year in both models.

CMS states that there were large increases in the average FFS risk score each year from 2016 to 2019, and identifies four factors associated with these increases:

1) Changes in the demographics of FFS Medicare beneficiaries
2) Changes in the case-mix of FFS Medicare beneficiaries

[40] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

3) More complete diagnosis coding of FFS Medicare beneficiaries due to the increased penetration of alternative payment models
4) The implementation of ICD-10

We are concerned that CMS has not provided stakeholders with the information necessary to understand how the FFS normalization factors were developed. The explanations above are very high-level and CMS has not released data, research, or analyses supporting these explanations.

Recommendation: We urge CMS to release more granular details and analyses that show the relative contribution of each factor identified as impacting the continued growth of FFS risk scores as well as data that can be used by stakeholders to validate the CMS methodology.

In addition, data that is publicly available: (1) suggest that CMS has overestimated the normalization factors; and (2) undermine the four factors identified above.

Overestimation of Normalization Factor

The FFS normalization factor has reduced payments to the MA program by roughly 2-3% on average for four consecutive years. This adjustment is one of the most impactful components of the MA payment methodology. A recent analysis by Wakely, which attempted to validate the CMS results by calculating average risk scores using the 2013 to 2018 LDS claims data, suggests that CMS may have overestimated the average risk score trend from 2014 to 2018 by 0.5 percentage points. Applying this trend to 2021 would result in a normalization factor of 1.051, which is significantly lower than 1.106 as estimated by CMS.[41]

Year	2020 Final Notice	2021 Advance Notice	Wakely (from LDS)
2014	0.999	N/A	0.978
2015	1.000	1.001	0.980
2016	1.021	1.021	1.001
2017	1.034	1.035	1.012
2018	1.055	1.054	1.018
2019	NA	1.069	NA
Average Trend	1.46%	1.70%	0.99%
Years of trend (denominator to payment year)	5	6	5
FFS Normalization Factor	1.075	1.106	1.051

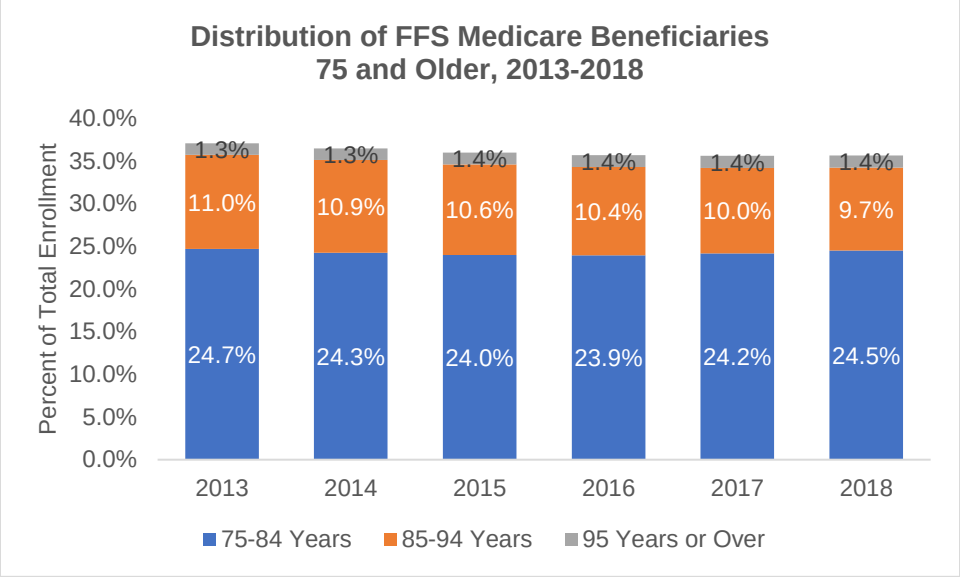
We also encourage CMS to consider the evolving relationship between the FFS normalization factor and the coding pattern adjustment over time. If FFS risk score growth continues to accelerate relative to the MA population, as CMS has suggested, then the combination of the FFS normalization factor and coding

[41] It is important to note that Wakely did not have access to 2019 claims data, so the five-year period reflected in this estimated normalization factor is different from that used by CMS.

pattern adjustment may reduce MA payments below what FFS Medicare would spend for a comparable beneficiary.

Changes in Demographics

CMS cites changes in demographics as a driver of rising FFS Medicare risk scores. By changes in demographics, without further detail we assume CMS is suggesting that beneficiaries in FFS Medicare are becoming older on average. However, analysis of Medicare enrollment data from the most recent CMS Program Statistics[42] suggests that the percentage and distribution of older Medicare beneficiaries has remained stable since 2013. In fact, the percentage of Medicare beneficiaries age 75 and older has fallen slightly over that time period (from 37.1% in 2013 to 35.6% in 2018).



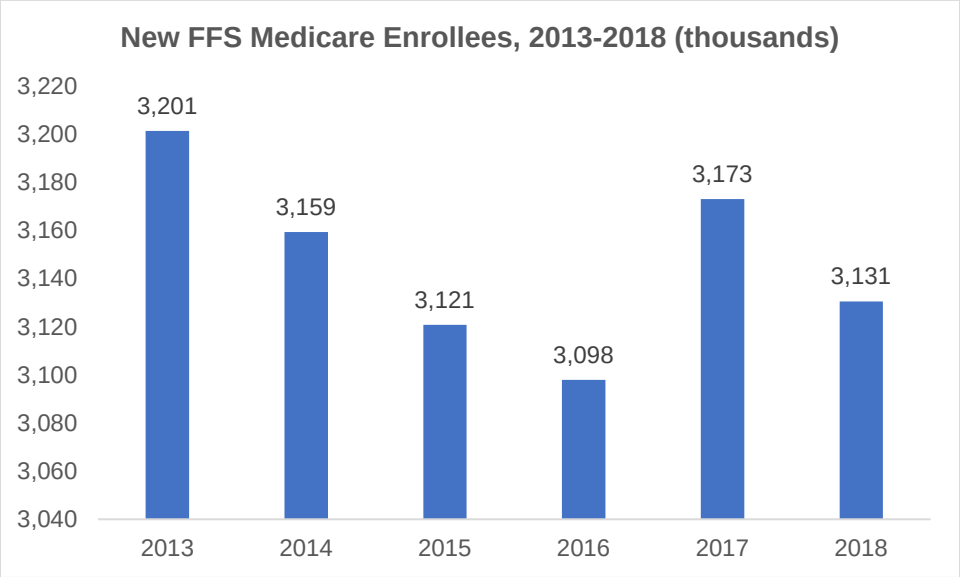
Looking at this trend another way, Wakely found that the distribution of community, new, and institutional enrollees has also remained consistent from 2012 to 2018.[43] The shift to community enrollees, who are relatively less healthy on average, has been gradual and the absolute difference (85.32% versus 83.60%) over this seven year time period is small.

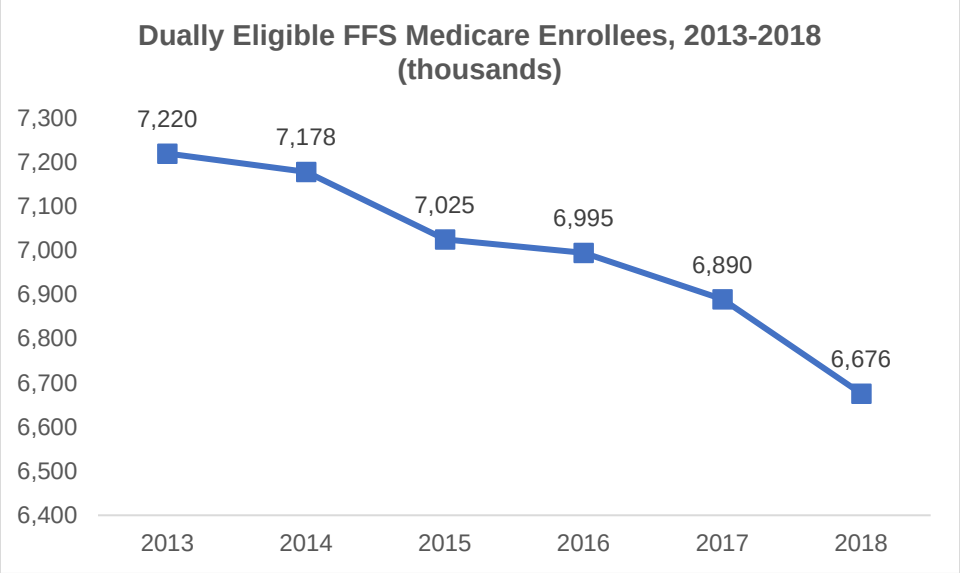
Year	Community	New Enrollee	Institutional
2012	83.60%	11.88%	4.53%
2013	83.68%	11.98%	4.34%
2014	84.52%	11.75%	3.73%
2015	84.73%	11.64%	3.63%
2016	84.73%	11.77%	3.50%
2017	85.04%	11.54%	3.42%
2018	85.32%	11.33%	3.35%

[42] CMS Program Statistics, 2018 Medicare Enrollment Section. Available online at: https://www.cms.gov/research-statistics-data-systems/cms-program-statistics/2018-medicare-enrollment-section#New
[43] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

Changes in Case Mix

CMS states that case mix is changing in FFS Medicare. This suggests that FFS Medicare beneficiaries on average are becoming sicker over time. However, CMS Program Statistics data indicate that the number of new Medicare FFS enrollees, while fluctuating over the past six years, increased in 2017 and 2018 after falling more consistently from 2013-2016. This trend suggests that the number of relatively healthier FFS Medicare beneficiaries has maintained or increased slightly over the past couple of years. In addition, the number of beneficiaries who are Medicare and Medicaid dually-eligible (they tend to be relatively less healthy on average) and who are enrolled in FFS Medicare has fallen consistently over the past six years. These trends contradict the CMS assertion that case mix in FFS Medicare is increasing.





Coding Patterns Due to Alternative Payment Models

Over the past several years alternative payment models – such as accountable care organizations, bundled payments, and other value-based payment arrangements – have increased in the FFS Medicare program. To the extent these alternative payment models incorporate targeted care management interventions to certain clinical populations and use risk adjustment models based on diagnosis codes, providers serving FFS Medicare beneficiaries would have increased incentives to more completely document the clinical conditions of their patients. CMS identifies this incentive as another driver of growing risk scores in the FFS Medicare population.

While it is true that alternative payment models have grown in FFS Medicare over the past several years, it is not clear what impact this trend has had on rates of diagnosis coding in the program. For example, certain alternative payment models including the MSSP impose caps on the rate of growth in risk scores for beneficiaries attributed to the payment model. Wakely found that despite a dramatic increase in MSSP beneficiary participation from 2016 to 2017, the annual trend in FFS Medicare risk scores did not differ in 2017 or 2018 from prior years.

Payment Year	MSSP Participants as % of Total	2017 CMS-HCC Risk Score	Annual Trend
2018	26%	1.018	0.6%
2017	23%	1.012	1.0%
2016	4%	1.001	2.1%
2015	3%	0.980	0.2%
2014	2%	0.978	
2014-2016			1.2%

A recent University of Michigan study also found that MSSP was not, in fact, associated with consistent changes in within-beneficiary risk scores.[44]

Recommendation: Given the lack of clear evidence in support of this trend, we request that CMS release detailed data that demonstrates the strength of the relationship between FFS Medicare alternative payment model penetration and risk score growth. For example, CMS could publish the results of multivariate regression analysis demonstrating a statistically significant relationship between FFS Medicare beneficiary penetration in alternative payment models and risk score growth over time.

ICD-10 Implementation

CMS first observed a large increase – over 2% – in FFS Medicare risk scores from 2015 to 2016 after a sustained period of relatively minor year-to-year changes. This change occurred immediately following the introduction of ICD-10 codes on October 1, 2015. Since then, the FFS program has shown annual increases in the average risk score of 1-2%. In the 2021 Advance Notice, CMS identified the implementation of ICD-10 as another driver of sustained FFS Medicare risk score growth over the period 2015 to 2019, but stated the agency expects "the effect on the change in average risk score from implementing ICD-10 to stabilize moving forward" without any further explanation. It is also important

[44] Markovitz, Adam A., et al. Risk adjustment in Medicare ACO program deters coding increases but may lead ACOs to drop high-risk beneficiaries. *Health Affairs* 38.2 (2019): 253-261.

to note that both the 2017 and 2020 CMS-HCC models were calibrated using ICD-9 diagnosis codes but are being applied to ICD-10 diagnosis codes in determining risk scores for 2016 and beyond.

If the transition to ICD-10 does account for the year-over-year increases in FFS Medicare risk scores, this would suggest the normalization factors calculated by CMS are not capturing true growth in risk scores but are capturing differences between ICD-9 and ICD-10. These differences could include provider coding practices in using ICD-9 versus ICD-10, differences between how ICD-9 versus ICD-10 codes map to the HCCs used in the risk adjustment model, and an underlying discrepancy between how the 2017 and 2020 CMS-HCC risk adjustment models were estimated versus how they are applied in payment. This discrepancy is exacerbated by the increasing length of time from the model estimation year (2015) to the payment year (2021). CMS has not indicated whether the agency has conducted an impact analysis of ICD-9 versus ICD-10 coding on FFS Medicare risk score growth over time.

Recommendation: CMS has yet to fully explain the relationship between ICD-10 implementation and FFS Medicare risk score growth since 2015. To understand how the normalization factor is derived as well as how the risk adjustment model is being applied in payment, it is critical that CMS release its analysis showing the impact of ICD-10 on the normalization factor for 2021, as well as other data and analyses showing any changes in this impact over time. Furthermore, we request that CMS release data supporting its claim that the impact of ICD-10 implementation will stabilize over time – without these data it will not be possible to validate the impact.

Finally, in the 2020 Rate Announcement, CMS reaffirmed its interest in calibrating a model with ICD-10 diagnoses.

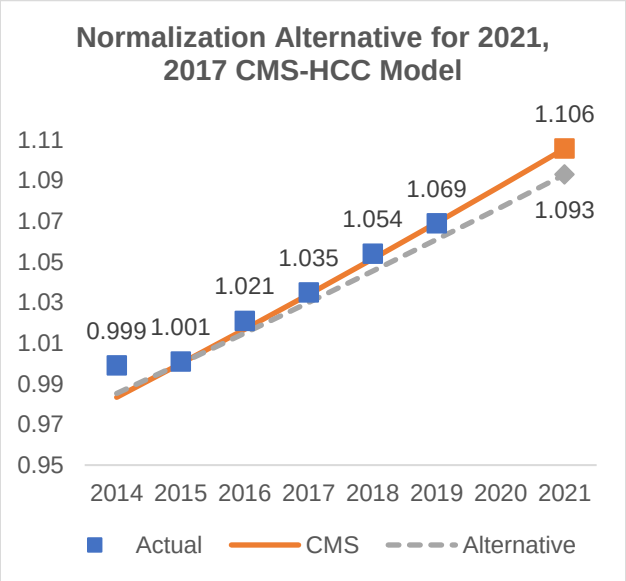
Recommendation: Consistent with our comments in response to the 2020 Advance Notice, we continue to encourage CMS to release information on the impact of recalibrating the risk adjustment model using only years of data in which ICD-10 has been fully implemented (i.e. 2016 and later). Recalibration of the risk model using ICD-10 data could lead to material changes in the risk adjustment model and the industry will need significant lead time to understand the impact and provide comment to the agency.

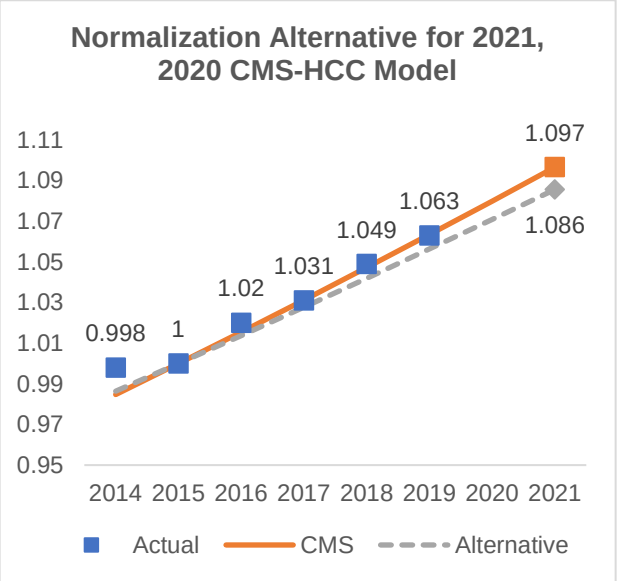
Smoothing Adjustment for 2021

In response to concerns raised by commenters on the 2020 Advance Notice regarding the magnitude of the FFS normalization factor, CMS noted that including data from prior years based on ICD-9 codes had a smoothing effect on the normalization factor:

> *Since 2015, when ICD-10 was first implemented, the FFS risk score has increased by 1.8 percent per year on average. By including two years without ICD-10 diagnoses (2014 and 2015) the average increase in FFS risk score decreases to 1.4 percent per year. While there is inherent uncertainty with any prediction of future values, the five year trend already includes two years that do not exhibit the same increase observed from 2016 to 2018, which provides a smoothing effect in the event the FFS risk score increase slows down in the future.*

Recommendation: In order to preserve this smoothing effect in 2021 while the risk adjustment models remain calibrated on ICD-9 diagnoses, we recommend that CMS continue to include two years of FFS risk scores based on ICD-9 codes. To do so, CMS should use six years of data to calculate the normalization factor trend by keeping 2014 data in the calculation. If CMS included 2014 data in the calculations, the normalization factor for the 2017 CMS-HCC model would be 1.093 and the normalization factor for the 2020 CMS-HCC model would be 1.086.





As shown in the graphs above, the grey dotted lines – which are linear functions that fit the 2014 to 2019 data – appear to be a more accurate representation of the values for 2014 to 2019 than the orange solid lines, which are linear functions that fit the 2015 to 2019 data, as CMS has proposed.[45] Note that this analysis is based on the FFS normalization factor trend data included in the 2020 and 2021 Advance Notices and was conducted independently of the analyses described above suggesting the normalization factor may not be valid.

Technical Expert Panel

Recommendation: We also continue to recommend that CMS establish a Technical Expert Panel (TEP) on the MA risk adjustment model, which would address issues such as FFS normalization and any model recalibration activities. This TEP would be an excellent approach for considering alternative methodologies to developing the FFS normalization factor or how recalibration of the risk adjustment model using ICD-10 data should be undertaken. Such a collaboration would also allow for substantive analysis and discussion of changes to the risk adjustment model outside of the annual Advance Notice process, which only provides 30 days for analysis and comment (and 60 days for changes implemented per the Cures Act). AHIP and its members would welcome the opportunity to participate on such a TEP.

There are many examples of TEPs and other Federal Advisory Committees across the FFS Medicare payment systems, including for the Medicare Physician Fee Schedule as well as for hospital outpatient payment, clinical diagnostic laboratory tests, and the ESRD prospective payment system.[46] 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.

[45] The 2014 data points are from Part II of the 2020 Advance Notice. Because CMS is using the same 2017 CMS-HCC and 2020 CMS-HCC models that it proposed in 2020 (the 2020 model was referred to as the Alternative PCC model in the 2020 Advance Notice), the same data points for 2014 can be used for this analysis.
[46] For the Medicare Physician Fee Schedule, see: https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc. For other Federal Advisory Committees serving CMS, see: https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA.

Section M. Encounter Data as a Diagnosis Source for CY 2021 (pp.40-41)

For 2021, CMS is proposing to increase the percentage of risk scores based on diagnoses submitted through the EDS to 75%, up from 50% in 2020. In its proposal, CMS would continue linking the phase-in of encounter data to the phase-in of the 2020 CMS-HCC model. The 2020 CMS-HCC model would also continue to use encounter data, supplemented with inpatient diagnoses submitted to RAPS, to determine its portion of the risk score.

Over the past decade, AHIP's members have dedicated considerable effort and resources to develop an infrastructure that captures comprehensive information on MA treatment and cost patterns through encounter data and remain fully committed to the submission of complete and accurate MA encounter data. However, we continue to be concerned with the management of the EDS related to an ongoing lack of transparency, persistent operational problems, and its use as a source of funding cuts.

Transparency

As we have noted in prior comments to the agency, we believe CMS has failed to implement recommendations issued by the Government Accountability Office (GAO) in July 2014[47] and January 2017[48] to "fully assess data quality before use," including for payment purposes. While CMS has undertaken many activities to improve encounter data submission and reporting over the past several years, CMS has not publicly released a comprehensive analysis of the completeness, accuracy, and reliability of encounter data. The most detailed analyses of encounter data released publicly to date have been conducted by MedPAC.[49]

Recommendation: We urge CMS to release a comprehensive analysis of the completeness, accuracy, and reliability of encounter data for public review and comment.

In addition, we have concerns with the process through which CMS may update the "filtering logic" used to determine which diagnoses submitted on encounter data records can be used in the calculation of beneficiary risk scores. CMS is currently using a filtering logic that was finalized in December 2015. The draft filtering logic had been released via a Health Plan Management System memo for public comment, but the final version was issued without any modifications nor response to the comments CMS had received from stakeholders. Furthermore, Wakely found that this filtering logic results in FFS Medicare risk scores 3% lower than the existing RAPS based filtering logic.[50] If CMS continues to phase-in encounter with the 2020 CMS-HCC model at the current rate, encounter data will comprise 100% of beneficiary risk scores in 2022; the role of this filtering logic in risk adjustment and the process through which it is updated will only grow in importance once encounter data are the sole source of diagnoses for risk adjustment.

Recommendation: Given that the filtering logic establishes a substantive legal standard governing, and has a substantial impact on, payment rates, we believe CMS is required to include it in a formal notice-

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[47] 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
[48] 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
[49] See Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system [Chapter 7: Ensuring the accuracy and completeness of Medicare Advantage encounter data]. June 2019. Available online at: http://medpac.gov/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf?sfvrsn=0
[50] 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

and-comment rulemaking process. Accordingly, we urge CMS to establish the filtering logic through that formal process.

Persistent CMS Operational Issues

We appreciate CMS' efforts to correct operational issues with the encounter data, including the release of a fifth version of the MAO-004 reports (which identify the diagnoses that will be used by CMS to calculate risk scores after application of the agency's filtering logic), multiple final payment reconciliations to correct for prior errors, and a recent process change implemented to ensure that all encounter data records submitted by annual payment reconciliation deadlines are properly date-stamped.

However, CMS has failed to make a single final, correct payment to an MA plan using encounter data since 2016, when encounter data first represented a percentage of the risk score calculation. In July 2018[51], CMS acknowledged there are several outstanding issues with the MAO-004 reports and the resulting payments calculated using diagnosis included on these reports, such as:

- Labeling which version of the record is final;
- Processing records that delete certain diagnoses from a previously submitted record;
- Missing encounter data records that were submitted and accepted in EDS; and
- Blank data fields that indicate how certain encounter data records are linked together or whether the encounter data record is "allowed" for risk adjustment purposes.

In January 2019[52] CMS provided an update on its efforts to resolve these issues. The agency acknowledged that all issues remain outstanding and that CMS "will address any discrepancies in future [payment reconciliation] runs, once system changes have been made." Since that time, CMS has not provided any update on when the system changes to resolve these issues will be implemented or when the payment reconciliations will be re-run. These affected payment years go back to 2016, and presumably continue into 2020 payments.

According to the agency, "The number of records affected by these issues are relatively small (approximately 1.5% of records on average across all service years) in number" and "many of these are reporting errors that do not affect risk scores." However, without the release of any detailed data associated with these issues, it is not possible to confirm CMS' estimate that the impacts are small on average. MA plans may be unable to confidently close their past accounting and financial records due to uncertainty surrounding possible payment adjustments in prior years related to encounter data. These errors may also be concentrated among certain plans in certain years and have a material impact on payments and other significant, downstream consequences for plan compliance-related activities. MA plans also continue to face operational challenges with the submission of encounter data records, including limitations to the submission process that result in otherwise valid records being rejected by the system.

Recommendation: We request CMS dedicate the resources necessarily to immediately address all outstanding issues related to the processing and use of encounter data for payment purposes, including

[51] CMS, Risk Adjustment for EDS & RAPS User Group. July 19, 2018. Available online at: https://www.csscoperations.com/internet/cssc4.nsf/files/071918_RA_Webinar_Slides_5CR_072018.pdf/$FIle/071918_RA_Webinar_Slides_5CR_072018.pdf

[52] CMS, Risk Adjustment for EDS & RAPS User Group. January 17, 2019. Available online at: https://www.csscoperations.com/internet/cssc4.nsf/files/011719_RA_Web_Slides_CMS_5CR_012319.pdf/$FIle/011719_RA_Web_Slides_CMS_5CR_012319.pdf

corrections to the MAO-004 reports and restatements of all final risk adjustment reconciliations for payments years 2016 to present.

Funding Cuts

Although CMS estimates the impact of increasing the percentage of encounter data used to calculate risk scores in 2021 will be 0% year-over-year, we remain concerned that the Administration views encounter data as a source of savings in the Medicare program. In the FY 2019 President's Budget, the Office of Management and Budget estimated that fully phasing in the use of encounter data for risk adjustment would reduce MA spending by $11.1 billion over 10 years. Even more concerning is a proposal included in the FY 2021 President's Budget to recalibrate the MA risk adjustment model in 2024 using encounter data (rather than FFS Medicare claims data, as is used today) that would save $40.6 billion through 2030.

We strongly oppose the use of encounter data as a means to cut funding to the MA program. Such cuts, especially to the degree contemplated in the FY 2021 President's Budget, risk undermining plan abilities to innovate and deliver on the possibilities of new benefit flexibilities such as offering services to address social risk factors, expanding access to telehealth, and targeting interventions tailored to chronically ill populations.

In addition, consistent with our comments on risk adjustment above, we urge CMS to establish a more transparent process for considering the role of encounter data in the risk adjustment model. Any transition to a risk adjustment model calibrated using diagnoses from encounter data, particularly if intended to reduce MA spending, could lead to enormous uncertainty and dislocation for beneficiaries, providers, and MA plans.

Recommendation: It is incumbent upon CMS to provide stakeholders with meaningful transparency in the process, including adequate lead time, the public release of detailed data files for industry analysis, and multiple opportunities for notice-and-comment on the proposed policy. We recommend any major risk adjustment model changes be proposed with no less than two years of lead time and a comment period of 180 days for robust analysis and thoughtful consideration of the potential impacts, including potential consideration of a budget neutrality adjustment during any transition to a new model.

Attachment V. Updates for Part C and D Star Ratings

Measure Updates for 2021 Star Ratings

Improvement Measures (Parts C and D) (pp. 58-60)

In the Advance Notice, CMS includes the measures to be used to calculate the 2021 Parts C and D improvement measures. AHIP and its member plans have previously made recommendations to CMS to refine the improvement measure calculation, including operationalizing a hold harmless policy for consistently high-performing plans, to better reflect progress in plan performance. In the 2020 Final Call Letter, CMS indicated that it would consider stakeholder feedback on future improvements to the improvement measures.

Recommendation: We appreciate CMS' willingness to engage with stakeholders and recommend that the agency hold a user group call on the improvement measure calculation.

Part D Statin Use in Persons with Diabetes Measure (p. 60)

The Part D Statin Use in Persons with Diabetes (SUPD) measure has a weight of 1 for 2020 Star Ratings. Through rulemaking, CMS previously decided to classify the measure as an intermediate outcome

measure with a weight of 3 starting with 2021 Star Ratings, which is also reflected in the "2021 Star Ratings Improvement Measures" Table on page 60 of the Advance Notice. However, in the recently published CY 2021 and 2022 MA and Part D Proposed Rule, CMS indicates it "no longer believe[s] that is the appropriate classification." CMS is therefore proposing to reclassify the Part D SUPD measure as a process measure with a weight of 1 for 2023 Star Ratings. As we have previously commented, AHIP agrees that the Part D SUPD measure should be categorized as a process measure and receive a weight of 1 in Star Ratings. The measure developer, Pharmacy Quality Alliance (PQA), has also classified the measure as a process measure.[53]

Recommendation: Given CMS' recognition that the measure has been inappropriately classified and weighted, we recommend that CMS make a technical correction to existing regulations and thereby classify the measure as a process measure with a weight of 1, starting with 2021 Star Ratings (including for the improvement measure calculation), rather than wait to implement the change to 2023 Star Ratings.

2021 Star Ratings Program and the Categorical Adjustment Index (pp. 60-66)

CMS intends to continue the use of the categorical adjustment index (CAI) for 2021 Star Ratings. The CAI is an interim analytical adjustment CMS uses 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. In the Advance Notice, CMS identifies the Parts C and D measures eligible for CAI adjustments.

Recommendation: AHIP supports the continued use of the CAI in the Star Ratings system while CMS develops a long-term solution to this problem. However, as we have indicated in prior comments on this subject, we believe that CMS should hold plans harmless from a reduction in Star Ratings due to the CAI, given that the CAI is intended to be an interim analytical adjustment, and the specific impacts of SES are still being assessed by the Assistant Secretary for Planning and Evaluation (ASPE), the measure developers and endorsers, and other stakeholders.

Additionally, during this time we continue to strongly recommend that CMS refrain from pursuing its policy to terminate contracts based solely on low performance on Star Ratings for three consecutive years.[54] Until the related ASPE report on the impact of social risk factors on quality measure programs is released and CMS has fully implemented a long-term solution to address SES and other disparities in the Star Ratings program based on its findings, we urge CMS not to terminate contracts based solely on Star Ratings performance.

Extreme and Uncontrollable Circumstances Policy (pp. 66-67)

In the Advance Notice, CMS indicates its intention to continue to adjust Star Ratings to account for the effects of disaster-related events that occurred during the 2019 performance period. While AHIP supports adjusting 2021 Star Ratings for eligible contracts, we believe that CMS should engage with plans to assess whether the eligibility criteria for affected contracts should be expanded.

We understand that plans and their enrollees may have been impacted by disasters that occurred during the performance period for the 2021 Star Ratings but do not qualify for disaster relief under the current criteria. CMS explained in the 2020 Final Call Letter that its disaster relief policy is narrow in scope to ensure that adjustments made are limited to "specific geographic areas that experienced the greatest

[53] https://www.pqaalliance.org/measures-overview#supd
[54] February 6, 2019 CMS 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."

adverse effects from the extreme and uncontrollable circumstance and are not applied to areas sustaining little or no adverse effects." While we appreciate CMS' concern, we believe that applying such a narrow disaster relief policy could result in unintended consequences such as disqualification of areas that also faced significant operational and clinical systems impacts caused by an uncontrollable event during the performance period, but did not qualify under the specific criteria currently required.

Recommendation: CMS should engage with plans to consider ways to expand the current eligibility criteria for affected contracts while maintaining the overall integrity of the policy. Potential changes could include expanding the criteria to cover: disasters declared under a state or federal declaration, including a public health emergency such as COVID-19; other FEMA declarations, including those involving public or fire management assistance; and other uncontrollable circumstances such as drug recalls that cause significant disruptions to systems and access that would impact plan performance. CMS' policy should also ensure that non-affected contracts are not disadvantaged due to disaster-relief related Star Ratings adjustments. Additionally, we understand that in some cases, the extreme and uncontrollable events methodology can actually reduce Star Ratings for certain plans impacted in two or more consecutive years. We believe this was never CMS' intention, and therefore recommend that no such plan be adversely impacted under this policy. Finally, CMS should review and update related sub-regulatory guidance (e.g., provisions in Chapters 2 and 4 of the Medicare Managed Care Manual and Chapters 3 and 5 of the Prescription Drug Benefit Manual) to ensure that CMS' guidance related to disaster relief is clear and consistent.

Changes to Existing Star Ratings and Display Measures (pp. 67-72)

Transitions of Care (Part C)

In the Advance Notice, CMS solicits feedback on several updates that the National Committee for Quality Assurance (NCQA) is currently considering making to the Transitions of Care measure that is currently on the Star Ratings display page. CMS describes three NCQA proposals: (1) revise the requirement that information must come from one medical record from a specific provider to allow additional forms of information accessible to the provider, (2) revise the timeframe for the Notification of Inpatient Admission and Receipt of Discharge Information indicators to clarify expectations for documentation related to admissions or discharges that take place over the weekend, and (3) modify the Receipt of Discharge Information indicator that limits instructions to only those specifically given to the primary care provider (PCP) to allow for more data sources.

While we understand the importance of measuring transitions of care, we have several concerns and questions relating to data challenges and other issues affecting this display measure. For example, although NCQA has revised the "one medical record" requirement to support other communication forms, clarification is needed on how plans should indicate the use of other acceptable communication forms for this measure. We also recommend that communications from other types of providers that may support a beneficiary during a care transition count. For example, communications from a health plan's case management system should be allowed under the Notification of Inpatient Admission and Receipt of Discharge Information indicators. The changes to the measure will require additional training and changes to operations. We also understand that data collection challenges persist due to lack of interoperability of systems and facilities not having processes in place to provide notifications to the PCPs in a consistent and/or timely manner. CMS also does not provide information in the Advance Notice on how the changes to the Transitions of Care measure will impact the related Medication Reconciliation Post-Discharge Star Ratings measure. Additionally, NCQA's requirement that all four elements be completed may not appropriately account for variation of performance on the different elements. We are also concerned that

the measure specifications do not account for cases that involve out-of-network providers, a fact pattern that can make aspects of the measure more challenging.

Recommendation: Given the changes to this display measure and concerns and questions raised above, we do not support CMS' proposal to move the Transitions of Care measure from the display page to Star Ratings in 2023. Plans need sufficient time to understand, implement, and assess all proposed changes to this measure. Consistent with prior AHIP comments, we recommend that any new measure for Star Ratings should be fully tested and validated and material changes to a measure's specifications should be fully assessed prior to inclusion in Star Ratings.

Patient-Used Device Data for HEDIS (Part C)

CMS indicates that NCQA is considering adding additional sources of data to meet the numerator requirements of measures including, for example, incorporating data captured from patient-used devices for the Controlling High Blood Pressure measure.

Recommendation: We appreciate the update and support NCQA's intent to promote wider use of technology to facilitate the incorporation of patient data into clinical data repositories. We ask that CMS provide more details regarding the other Star Ratings program measures that would be impacted.

HEDIS: Cross-Cutting Exclusions (Part C)

CMS indicates that NCQA is continuing to consider and develop cross-cutting exclusions for Healthcare Effectiveness Data and Information Set (HEDIS) measures. They include exploring additional methods to identify individuals who require nursing home level care but reside in the community. NCQA is also exploring an exclusion for those receiving palliative care. CMS states that if approved, updates to existing exclusions and the new potential exclusion for palliative care would be implemented for measurement year 2020 and welcomes feedback on these potential updates.

Recommendation: We appreciate the update and support NCQA's efforts and CMS' plans to consider appropriate exclusions for applicable Star Ratings measures as some measures may not be clinically appropriate for certain individuals.

Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D)

CMS is considering PQA's recommendation to risk adjust the three medication adherence measures included in Star Ratings for certain beneficiary-level sociodemographic status (SDS) characteristics. In the Advance Notice, CMS also indicates that it would consider implementation of PQA's recommendations for future Star Ratings.

Recommendation: We appreciate the update and recommend that CMS provide more details about its plans and impacts on plan performance, including, for example, how the risk adjustments being recommended would impact measure scores and Patient Safety Reports that CMS provides Part D sponsors on these measures. We understand that drug recalls and other uncontrollable circumstances may also impact plan performance on medication adherence measures. CMS and PQA should consider input from our member plans on ways to address these issues.

Retired Display Measures for 2023 (pp. 72-73)

Osteoporosis Testing in Older Women (Part C)

CMS notes that NCQA is retiring the Osteoporosis Testing measure, a current Star Ratings Part C display measure, for the 2020 measurement year due to validity concerns. CMS indicates in the Advance Notice that due to NCQA's decision, CMS intends to remove this measure from the display page beginning in 2023.

Recommendation: We agree and support CMS' proposal.

Potential New Measure Concepts (pp. 73-79)

In the Advance Notice, CMS describes a number of possible future measures and measure concepts for the MA and Part D Star Ratings program. We recognize the significant effort that CMS has made to develop and codify the Star Ratings system, including guiding principles in the 2019 MA and Part D Final Rule for making improvements and updates to the Star Ratings[55], and efforts plans have put into their programs to achieve and maintain high Star Ratings. The guiding principles call for, among other things, that measures be developed by consensus-based organizations; that Star Ratings be a true reflection of plan quality and enrollee experience, treat contracts fairly and equally, and minimize unintended consequences; that data needed for measures be accurate, complete, and reliable; and that improvement on measures be under the plan's control. We continue to support these guiding principles and believe it is critical that CMS use them as the framework for assessing future measures for the program.

Recommendation: In this regard, we have significant concerns with the volume and variety of measures currently in Star Ratings, on the display page, and being proposed as future measures. We urge CMS to determine which measures (current and future) reflect the Star Ratings guiding principles, and assess the reporting and other burdens of individual and collective measures on providers, plans, and other stakeholders, as well as the impact of frequent changes of measure composition, specification, and thresholds on the ability of plans to design quality improvement programs.

In addition to applying its current set of guiding principles, CMS should continue to evaluate additional improvements to the Star Ratings methodology. For example, AHIP continues to urge CMS to develop cut points and publish them well in advance of the measurement period and ensure that the cut points reflect meaningful differences. Our view is that the elimination of pre-determined thresholds has impeded CMS' goal of promoting continued quality improvement. AHIP will provide more detailed comments on this issue in response to the recently published CY 2021 and 2022 MA and Part D Proposed Rule.

We also have the following specific comments on possible future measure concepts that CMS described in the Advance Notice.

End-Stage Renal Disease (ESRD) Measures (Part C)

CMS solicits feedback on ESRD measures. As more beneficiaries with ESRD are able to enroll in MA plans beginning in 2021, we support consideration of future quality measures on ESRD and/or chronic kidney disease.

[55] 83 CFR 16440, April 16, 2018 at p. 16521.

Recommendation: We recommend that CMS engage with plans to consider chronic kidney disease measures that may be administratively feasible and reliably measured at the contract level.

Prior Authorizations (Part C)

CMS indicates that it is developing a measure for the display page related to prior authorizations and is considering proposing it for future Star Ratings. Prior authorization is an important tool to ensure that patients receive safe, affordable, and effective care. AHIP appreciates that CMS continues to recognize prior authorization as a valuable tool to protect patients and has taken several actions to support its use in the MA and Part D programs. CMS has also expanded its use under FFS (e.g., durable medical equipment, advanced diagnostic imaging, cosmetic services).

AHIP and its member plans are committed to improving prior authorization programs to reduce unnecessary burden on providers, increase patient satisfaction, and improve quality and outcomes for enrollees. For example, AHIP is working with physicians, health insurance providers, and health IT companies on a new initiative to improve prior authorization functionality. Health plan portals have helped streamline the process by minimizing reliance on phone calls and fax, and this new initiative aims to leverage technology to further reduce the administrative burden on providers and identify best practices for more widespread adoption.

Part D plans are required to adopt a real time benefit tool (RTBT) that integrates with at least one prescriber's ePrescribing system or electronic health record (EHR) by 2021. The RTBTs are required to provide clinicians with formulary and benefit information, including enrollee cost-sharing information, clinically appropriate formulary alternatives (when available), and the formulary status of each drug presented, including any utilization management requirements applicable to each alternative drug. We believe that supporting these efforts is the best way to encourage improvements to the prior authorization process at this time.

Recommendation: AHIP is concerned that development of a Star Ratings measure on prior authorizations could distract from these innovations. Moreover, CMS already assesses performance of plans on administration of prior authorizations through various oversight activities, including reporting requirements and program audits. Developing a prior authorization measure is both duplicative and unnecessary. Furthermore, a prior authorization measure does not align with HHS' or CMS' quality strategy to focus on evidence-based clinical quality outcomes measures. We continue to urge CMS to apply the guiding principles in its regulations, including a focus on tested, outcomes-based quality measures, rather than develop measures that are not aligned with the agency's strategy and framework.

HOS Measures (Part C)

CMS proposes a new longitudinal measure from the Medicare Health Outcomes Survey (HOS) to complement the measurement of the physical health status of MA beneficiaries. CMS also indicates that it plans to post the longitudinal Physical Functioning Activities of Daily Living (PFADL) change measure on the 2021 and 2022 display pages and may consider the measure for future Star Ratings.

We understand that there is significant variability in plan performance year to year on HOS measures and research has identified reliability issues with patient reported outcome measures.[56] Another example of reliability concerns with HOS measures is described in the Advance Notice. CMS indicates that NCQA is planning on retiring the Osteoporosis Testing in Older Women measure (Part C measure currently on the

[56] https://www.rand.org/pubs/research_reports/RR1844.html

display page) due to concerns about the validity of this survey measure and the ability of women to accurately recall their screening history.

Recommendation: Accordingly, we have significant concerns with CMS considering additional HOS measures before certain fundamental questions about reliability are addressed. We also believe providing plans with access to inter-unit reliability data for HOS measures would be helpful. We will provide more detailed comments on reliability issues in our response to the Proposed Rule, which included proposed changes to the HOS measures for 2023 Star Ratings.

Generic Utilization (Part D)

CMS indicates it plans to develop measures to assess generic and biosimilar utilization in the Medicare Part D program. However, CMS acknowledges that "[g]eneric dispensing and generic substitution rates, 82% and 91% respectively in 2017, are high on average across the Part D program." Part D plans recognize the importance of encouraging enrollees to utilize the most cost-effective care available. At the same time, generic or biosimilar drugs are not always the lowest cost option for a beneficiary. Moreover, in some cases the net costs of these drugs are higher than brands or reference biologics. It is important that Part D plans retain flexibility to determine the most appropriate tiering structure, including allowing mixed generic and brand tiers based on cost rather than characteristic, to offer the lowest-cost package of benefits to beneficiaries and taxpayers.

In addition, a measure aimed at generic or biosimilar utilization would not be consistent with key guiding principles for the Star Ratings program. For example, the measure would not be developed by a consensus-based organization; would not be a true reflection of plan quality and enrollee experience; and could have the unintended consequence of increasing premiums or other plan/program costs.

Recommendation: We do not support the development of these measures for Star Ratings and urge CMS to not proceed with the development of a measure of this type.

Initial Opioid Prescribing (IOP) Measures (Part D)

CMS invites feedback on three IOP measures developed and endorsed by PQA: Initial Opioid Prescribing at High Dosage (IOP-HD), Initial Opioid Prescribing for Long Duration (IOP-LD), and Initial Opioid Prescribing for Long-Acting or Extended Release Opioids (IOP-LA).

AHIP appreciates CMS' leadership and continued focus on opioids. AHIP member plans are key 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 (DMPs) in accordance with CMS regulations and federal legislation.

Recommendation: While AHIP and our member plans will continue strong support for CMS' overall efforts in this area, we are concerned about the volume of opioid measures under development and consideration, on top of existing patient safety measures. We would appreciate CMS' careful consideration and assessment of these and other opioid related measures on the display page or under consideration for the Star Ratings program to ensure that measurement and reporting requirements align with updates made to the opioid drug management program. We also recommend that CMS keep these measures on the display page and engage with plans to continue to evaluate (including consideration of appropriate exclusions), refine, and gain experience with these measures.

Net Promoter Score

CMS invites feedback on adding a question related to the Net Promoter Score (NPS) or customer loyalty to the MA and Prescription Drug Plan (PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CMS would add a question related to the NPS to the CAHPS survey and use it to develop a future Star Ratings measure. We believe that existing CAHPS survey questions such as member's rating of the health plan already provide insight into the member experience.

Recommendation: We agree with concerns CMS summarized in the Advance Notice that the NPS could be more volatile and therefore less reliable in comparison to other measures focused on patient experience. We therefore do not recommend that CMS add the NPS to the survey.

AHIP Detailed Comments on Contract Year 2021 Part C Benefits Review and Evaluation

CMS is proposing to update the calculations of the maximum out-of-pocket (MOOP) limits, service-specific per-member per-month (PMPM) cost-sharing limits, and total beneficiary cost (TBC) to reflect the historical spending patterns of beneficiaries with end-stage renal disease (ESRD) who have previously been excluded from the methodology. While AHIP supports CMS updating its methodology in this way, we are concerned that such a change may impose greater costs on all Medicare Advantage (MA) enrollees while not addressing the underlying, fundamental problem of payment inadequacy in the state ESRD benchmark rates. We discuss this issue in more detail in our comments in response to the Advance Notice.

MOOP Limits

CMS requests feedback on potential changes to MOOP limits for 2021 in light of the Cures Act requirement that beneficiaries with ESRD be able to enroll in MA plans. The methodology that CMS currently uses to establish the MOOP limit uses FFS Medicare claims data for beneficiaries without ESRD. For 2021, CMS proposes to partially incorporate FFS Medicare claims costs for ESRD beneficiaries into the calculation of the MOOP limits, which would increase the MOOP by an additional $400. Specifically, CMS chose to incorporate 40% of the ESRD cost differential in attempt to ensure "that there is not a significant and sudden shift in the MOOP limits."

AHIP supports CMS incorporating costs for beneficiaries with ESRD into the methodology used to establish MOOP limits. From an actuarial perspective, it is appropriate to reflect the claims experience of this population in the calculation now that MA enrollment restrictions have been lifted. However, CMS projects that 50% of the beneficiaries with ESRD anticipated to enroll in MA by 2026 will enroll in 2021.

Recommendation: While we have questions about whether CMS' projection understates actual enrollment, we recommend at a minimum that CMS reflect its full estimate and therefore incorporate 50% of the costs of ESRD enrollees in the MOOP limit calculation (rather than 40%).

Part C Cost Sharing Standards

Similar to its proposal on the MOOP limits, CMS is proposing to incorporate 40% of the historical spending of beneficiaries with ESRD into the calculation of the service-specific PMPM cost-sharing limit for inpatient hospital acute 60-day length of stay. This results in a mandatory MOOP for this service category of $4,816. CMS also proposes to include spending for beneficiaries with ESRD in its calculation of cost-sharing limits for inpatient hospital psychiatric benefits, although CMS estimates these benefits will not be impacted by the change. For all other benefits, CMS proposes to exclude beneficiaries with ESRD from the FFS Medicare spending data used to set cost-sharing limits for specific services because these specific benefits categories would not be affected by the change.

AHIP also supports CMS in incorporating costs for beneficiaries with ESRD into the methodology used to establish cost-sharing limits for specific benefit categories.

Recommendation: As CMS projects that 50% of the beneficiaries with ESRD anticipated to enroll in MA by 2026 will enroll in 2021, we recommend that CMS reflect 50% of the costs of ESRD enrollees in the specific benefit cost-sharing limit calculations (rather than 40%). We also recommend that CMS incorporate these costs into the calculation of all specific benefit cost-sharing limits – while this change may not impact any of the other benefit categories now, it may in the future and the justification for doing so is appropriate for all benefit categories and not just inpatient hospital services.

TBC

CMS proposes to take into account FFS Medicare claims costs for ESRD beneficiaries in the out-of-pocket cost (OOPC) model used to calculate and evaluate TBC. As a result, CMS is proposing to increase the TBC change threshold from $36.00 PMPM in CY 2020 to $37.00 PMPM in CY 2021. In addition, CMS proposes to evaluate TBC differently for plans with an increased Quality Bonus Payment (QBP)/rebate percentage and overall payment adjustment greater than $37.00 PMPM, plans with a decreased QBP/rebate percentage or Star Rating below 3.0 and an overall payment adjustment less than $37.00 PMPM, and all other plans.

We support CMS in increasing the TBC amount to reflect additional program costs associated with enrolling beneficiaries with ESRD. However, we are concerned the $1 PMPM increase in TBC may not be adequate for many plans. An analysis by Wakely found that if the MOOP level is increased to $7,550, the proposed $1 increase in the TBC threshold will not be adequate to cover this impact for most plans.[57] Among several general enrollment plans with a $6,700 MOOP tested by Wakely, only one had an OOPC change of less than $1 when the MOOP increased to $7,550, and the majority of plans had an OOPC change ranging from $1.10 to $1.91. For plans with a MOOP between $3,400 and $6,700, the OOPC changes would be significantly greater if their MOOP levels increased by $850 (the same absolute increase in the mandatory MOOP level).

Recommendation: For 2021, we urge CMS to increase the TBC threshold to at least $38.00 PMPM to account for the impact of increasing the MOOP and cost-sharing limits as beneficiaries with ESRD become eligible to enroll in MA plans.

Additionally, CMS had indicated in the 2019 draft Call Letter that it was considering eliminating TBC in future years. The Part C Bidding Instructions do not allude to 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.

Recommendation: 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.

[57] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/2021-medicare-advantage-advance-notice/

www.wakely.com

2021 Medicare Advantage Advance Notice

Summary and Analysis

March 4, 2020

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Executive Summary

On January 6, 2020 and February 5, 2020, the Centers for Medicare and Medicaid Services (CMS) released the contract year (CY) 2021 Advance Notice Parts I and II (Notice), respectively. Shortly thereafter, CMS published two key memoranda:

- Contract Year 2021 Part C Benefits Review and Evaluation
- Contract Year 2021 Final Part D Bidding Instructions

America's Health Insurance Plans (AHIP) has retained Wakely Consulting Group LLC. (Wakely) to provide a financial impact summary report of the information presented in the Notice as well as an analysis of the financial impact of ESRD beneficiaries being allowed to proactively enroll in MA plans beginning in 2021 and the proposed FFS normalization factors.

Key highlights of our analysis are:

- The CY2021 fee-for-service (FFS) growth rate is significantly lower than expected as compared with previous CMS projections, including projections published just a few months ago in the CY2021 Early Preview.
- Kidney acquisition costs, which CMS is proposing to exclude from Part C benchmark rates, may have been overestimated by CMS, will have highly variable impacts by county when carved out, and the overall impact of their removal was not reflected in the Net Payment Impact estimate from the February 5, 2020 CMS Advance Notice Part II Fact Sheet.
- The state end-stage renal disease (ESRD) benchmark rates currently do not cover the costs of Medicare beneficiaries with ESRD on average, and many counties face severe underpayments. The allowance of ESRD beneficiaries to proactively enroll in Medicare Advantage Organizations (MAOs) will increase costs that will not be fully offset by the maximum out-of-pocket (MOOP) limit and Total Beneficiary Cost (TBC) changes proposed by CMS.
- The Part C FFS normalization factor continues to trend upward, which reduces payment to plans. Wakely analysis of the Limited Data Set (LDS) shows a substantially lower overall trend than the CMS calculation, and mixed results when we attempted to validate some of the explanations cited by CMS for the increasing normalization trend. These results are concerning and indicate further study is warranted.

The sections below provide additional detail and discussion of these issues.

Growth Rate and Expected Average MA Payment Change for 2021

Estimated MA Payment Change for 2021

The CY 2021 FFS growth rate, which is now the major driver of Part C benchmark rates, is 2.57%. The MA growth rate is 4.52%. The FFS growth rate is 189 basis points (bps) lower than the December 3, 2019 estimate in the CMS Early Preview of growth rates, indicating that CMS and the Office of the Actuary (OACT) continue to see new information emerge that affects cost projections even over a matter of two months. Both announced growth rates represent substantial decreases as compared with the December 3, 2019 and April 1, 2019 projections.

Table 1 compares these growth rate estimates.

Table 1 – CMS Projected 2021 Growth Rate

Component	2021 Advance Notice, Part II	Dec-2019 Early Preview	2020 Final Notice
Non-ESRD FFS	2.57%	4.46%	5.00%
Non-ESRD MA	4.52%	5.28%	4.84%

In the February 20, 2020 CMS User Group call, the Office of the Actuary (OACT) described the changes as being primarily driven by updates to historical enrollment and claims. More specifically, OACT offered the following rationale for the downturn in non-ESRD FFS growth rates:

- Revised 2017 and 2018 FFS enrollment: -80 bps
- Re-classification of Part A home health spending from non-ESRD to ESRD, bad debt, improvements in modeling of incurred claims for Part A buy in beneficiaries, and re-mapping of some Part B services to new benefit categories: -70 bps
- Additional run-out and changes to the 2020 projection factors: -39 bps (implied)

Taking into account other component changes to the benchmark rates, Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2020 to 2021 will be 3.13%. We further estimate that the nationwide average change in the blended MA Payment will be 0.82%.

Table 2 presents the components of these changes.

Table 2 – Estimated Change in MA Payment – 2020 to 2021

Component	Wakely Estimated Annual Change	CMS Estimated Annual Change
Effective Growth Rate	3.06%	2.99%
Rebasing/Re-pricing (AGA)	0.00%	0.00%
Change in Star Ratings	0.52%	0.23%
Kidney Acquisition Cost Removal	-0.43%	0.00%
Total Benchmark Change	**3.13%**	**3.22%**
MA Coding Pattern	0.00%	0.00%
Risk Model Transition	0.25%	0.25%
FFS Normalization	-2.48%	-2.54%
Total Risk Score Change	**-2.24%**	**-2.29%**
Total	**0.82%**	**0.93%**

Note that our estimate of the change in Star Ratings is based on static January 2020 enrollment. Changes in enrollment impacting Star Ratings could result in a reduced estimate and therefore a lower bottom line impact relative to what CMS originally estimated.

Below is a brief definition of each of the elements in Table 2.[1]

> ***Effective Growth Rate***. This is the combined impact of the FFS growth rate (2.57%), applicable percentage, and the benchmark cap. The requirement that restatements of prior estimates are factored into the growth rate produces a change that is well below the total growth rate for 2021, and is also well below the 2021/2020 trend of +4.53% based on CMS's current projection of 2020 and 2021 Non-ESRD FFS costs (i.e. $923.20 and $964.99, respectively).
>
> We estimated the average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county to be 0.18%. The applicable percentage varies according to a county's quartile ranking. The 2021 county quartiles

[1] The estimates in Table 2 do not consider the potential impact of changes to the Health Insurance Provider (HIP) fee for 2021. The HIP fee imposed by the 2010 Affordable Care Act was in effect for CY 2020, but is being repealed beginning in 2021 as a result of the December 20, 2019 Further Consolidated Appropriations Act.

are determined by the 2020 FFS rates. The 0.18% increase is driven by increased enrollment in MA plans with higher than average applicable percentages.

The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can change year-to-year as plans star ratings change, and as the MA growth rate – formally referred to as the National Per Capita Medicare Growth Percentage (NPCMGP) – varies from the FFS trend. The 2021 MA growth rate of 4.52% is higher than the FFS growth rate of 2.57%, which contributes to a positive year-over-year impact of +0.32% (i.e. the cap applies for fewer contracts than before). The impact of benchmark caps by county vary depending on a contract's star rating. Note that our measure does not include consideration for changes in star rating from payment year 2020 to payment year 2021.

The difference between the FFS growth rate and the MA growth rate is materially higher than in prior years. Given that Medicare Advantage represents about one third of total Medicare spending, if we assign a two-thirds weight to the 2.57% FFS growth rate, it implies that CMS projects a MA payment rate change of over 8.4%. Applying a similar exercise to the 2020 rates produces an implied MA growth rate of 6.2%. We do not have details on this MA payment portion of the CMS projection, but it is unclear what components of MA payment could account for this significant an increase.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks between 2020 and 2021. This is based on a static enrollment mix, so it only reflects changes in average star ratings by contract, and not a shift in enrollment toward plans with higher or lower star ratings. In addition, it does not include terminated contracts or the potential for new contracts with a 3.5% bonus in 2021. We assume that the CMS estimated impact of Star Rating changes includes both changes in the ratings as well as change in enrollment by plan, although CMS does not provide a description of its method in the Fact Sheet.

Kidney Acquisition Costs. The 21st Century Cures Act requires that Medicare cover organ acquisition costs for kidney transplants for MA beneficiaries. The Act also stipulated that these costs be removed from the calculation of Part C benchmark rates.

CMS will reflect the removal of these costs at the county level, similar to the process for removing Indirect Medical Education (IME) payments. Using January 2020 MA enrollment, Wakely estimates the average impact nationwide to be -0.43%[2], due to 2020

[2] Using the values published by CMS results in a nationwide impact of -0.35%, but this is based on enrollment prior to the January 2020 values, and so would not include annual enrollment changes for 2020.

MA enrollment being disproportionally in counties impacted more adversely than average by the change.

It is important to note that the nationwide non-ESRD FFS growth rate of 2.57% includes kidney acquisition costs (KAC). The removal is only reflected at the county level. It should also be noted that the carve-out factors vary quite drastically at a county level (from 0.0% to 4.29%). Many counties in Puerto Rico are among the highest in terms of KAC.

In Part II of the Notice, CMS indicated that the anticipated impact of removing KAC from FFS experience would result in a weighted average reduction in MA non-ESRD rates of $4.00 PMPM. The comparable impact for ESRD Dialysis State rates was $36.00. It is not clear how these estimates relate to Table 29 in the Proposed Rule, which shows a CMS estimated KAC of $2.82 PMPM for 2021, and CMS did not provide additional details as to how it identified kidney acquisition costs.

We attempted to conduct reasonableness tests on the CMS estimates by calculating the number of kidney transplants in the 2014 through 2018 Limited Data Set (LDS) data. We compared the number of kidney transplants nationwide in LDS to Table 26 in the Proposed Rule. For 2017, we identified about 567 kidney transplants in LDS (note that LDS is a 5% sample). Assuming full credibility of the kidney transplant count, scaling the counts up to100%, we get 11,340 kidney transplants in 2017, which compares with 15,346 cited in the Proposed Rule. While we would not expect such a comparison to be exact given the nature of sampling, we would expect to be reasonably close, yet our estimate is 26% below the CMS statistic.

We also compared transplant counts in 82 counties with carve-out factors above 1.0% and found that only 20 of them had identifiable kidney transplants in any of the five years of LDS data reviewed. Again this is not an exact comparison, but we would have expected to see a comparably higher number of transplants, especially for those counties with high carve-out factors (greater than 2%). Table 3 displays the top ten counties with the highest KAC carve-out factors and the total number of kidney transplants from LDS (excluding Puerto Rico).

Table 3 – Top 10 Counties with Highest KAC Carve-out Factors [1]

State	County	KAC carve-out factor	Total Kidney Transplants (2014-2018 LDS)
OREGON	COLUMBIA	2.79%	0
WISCONSIN	DANE	1.85%	6
LOUISIANA	PLAQUEMINES	1.85%	0
CALIFORNIA	SAN FRANCISCO	1.66%	3
LOUISIANA	ORLEANS	1.66%	7
MISSOURI	ST LOUIS CITY	1.64%	6
NORTH CAROLINA	ORANGE	1.60%	0
MINNESOTA	OLMSTED	1.52%	1
PENNSYLVANIA	MONTOUR	1.44%	1
MINNESOTA	DODGE	1.35%	0

[1] Excluding Puerto Rico

As noted above, Puerto Rico counties have some of the highest carve-out factors. Puerto Rico's FFS rates (including IME and KAC) are on average about 50% less than the national average FFS USPCC. Given the starting Puerto Rico FFS PMPM is significantly lower, and the carve out factors are greater than average, Puerto Rico as a whole will experience greater year over year decreases in the benchmarks compared with the nationwide average.

Table 4 – Dollar Impact of KAC Removal

	KAC carve-out factor	FFS Rate Including IME	$ Impact of KAC Removal
Nationwide	0.35%	$964.99	$3.35
Puerto Rico Only	1.90%	$490.26	$9.31

The removal of FFS KAC from total FFS costs will have a negative year over year impact on revenue that is likely to be disproportionate to the decrease in expected costs for MA plans. This occurs because there is a materially higher mix of ESRD beneficiaries in FFS than in MA, even after taking into consideration that additional beneficiaries are

likely to join MA plans. This disconnect will be particularly acute in counties with very high KAC reduction factors.

Part C Fee-for-Service (FFS) Normalization Factor and Transition in Weights. Part I of the Notice does not propose any changes to the 2017 CMS-HCC RAPS or 2020 CMS-HCC EDS risk models. The RAPS/EDS blend for CY 2021 is proposed to be 25%/75% as compared with 50%/50% for CY 2020. In the Fact Sheet, CMS estimates that the change in blend will have a +0.25% impact on MA risk scores.

The 2020 Part C FFS normalization factors were applied separately to the 2017 RAPS CMS-HCC model (1.075) and the CMS Payment Condition Count model (1.069), which were then blended 50%/50% to determine a beneficiary's risk score. For 2021, the blend of the two models is proposed to be 25%/75% 2017 RAPS CMS-HCC model (1.106) and 2020 CMS-HCC Payment Condition Count model (1.097), respectively. Calculating the change between the blended 2020 factor (1.072) and the proposed blended 2021 factor (1.0993), the impact is (1/1.072)/(1/1.0993) - 1 = -2.48%.

We believe this estimate differs slightly from the -2.54% estimate in the CMS fact sheet because CMS likely calculates the impact using actual RAPS and EDS risk scores, which impact the weighting.

Change in Coding Pattern Adjustment. The PY2020 coding pattern adjustment is -5.90%, which is the minimum adjustment required by the Affordable Care Act. This is the same adjustment used in CY 2020.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. For 2021, the removal of KAC will cause further variation by county. As noted above, the KAC removal impact varies significantly by county, ranging from no change to -4.3%.

CMS intends to rebase county FFS rates in 2021 (which is the basis of the "Specified Amount"); although, the rebasing will not be published until the Final Announcement. Table 5 shows the top five and bottom five growth rates by State (these changes include changes due to star rating, double bonus status, applicable percentage, benchmark cap, and KAC removal), as estimated by Wakely.

Table 5 is based on the January 2020 county level enrollment file and star rating information published by CMS. Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing.

Table 5 – States with Highest and Lowest Expected Benchmark Change

Rank	State	Change
1	AL	6.1%
2	NJ	5.4%
3	OH	5.1%
4	NE	5.0%
5	CT	4.7%
47	OR	1.8%
48	HI	1.7%
49	DC	1.6%
50	TX	1.6%
51	PR	1.1%

Benchmarks based on Part A and/or Part B Eligibility

Despite a past recommendation from the Medicare Payment Advisory Commission (MedPAC), with the exception of Puerto Rico benchmarks, CMS did not address the inconsistency of calculating MA benchmarks using FFS costs from beneficiaries eligible for Part A only, Part B only, and both Parts A and B even though beneficiaries joining MA plans must be eligible for both Parts A and B.

Based on an internal 2017 Wakely study, approximately 12% of FFS beneficiaries in LDS have only Part A or only Part B coverage. In that study, we estimated that excluding these members would increase nationwide average LDS costs by 2.8%.

It is also notable that the CMS method for determining a Direct Contracting Entity's regional expenditures under the Center for Medicare & Medicaid Innovation Direct Contracting model includes an adjustment to the MA ratebook to reflect only beneficiaries enrolled in both Parts A and B. Eligibility for Medicare Advantage also requires enrollment in both Parts A and B, so it is actuarially inconsistent not to also modify the ratebook for MA plans.

Analysis of the Financial Impact due to Changes in ESRD Beneficiary Eligibility

Beginning in 2021, ESRD beneficiaries can select an MA plan during open enrollment regardless of previous coverage. Wakely published a White Paper[3] on this topic in February 2019, highlighting the potential financial challenges MA plans may encounter with this eligibility change. This has been an area concern for the industry; organizations like Avalere, MedPAC, and Milliman have all published reports with the consistent theme that the risk exposure is unknown but potentially material, and that MA plans should evaluate the implications of this new change for future plan years.

Background and Recent Changes

Given that ESRD members will have the opportunity to actively enroll in general enrollment MA plans, these members will almost certainly be a higher percentage of the total MA population. In the April 1, 2019 Rate Announcement for CY 2020, CMS projected 144,500 ESRD beneficiaries enrolled in MA plans for 2021, which represents about 0.67% of all MA enrollees. If all ESRD beneficiaries enrolled in MA, they would then represent about 2.5% of MA enrollment.

While the proportion of ESRD beneficiaries in MA is low, the health expenditures are very high relative to the population size. In addition, Dialysis-Only ESRD benchmark growth rates have been very volatile over the last several years. Table 6 shows Dialysis-Only ESRD growth rates from 2017 through 2021.

Table 6 – Dialysis-Only ESRD Growth Rates

Year	Rate
2021 (Proposed)	2.80%
2020	-0.48%
2019	9.81%
2018	1.57%
2017	-1.84%

Wakely has done several analyses using both MA data and FFS data to evaluate financial implications for MAOs and identified a few areas where MA plans may face financial challenges

[3] For more background on the 21st Cures Act (Act) and details on ESRD payment methodology please refer to https://www.wakely.com/sites/default/files/files/content/increased-esrd-beneficiary-enrollment-flex-presents-potential-financial-challenge.pdf.

with the implementation of the Act. The historical Medical Loss Ratio (MLR) for the ESRD population is much higher than the general enrollment population. In addition, we expect plans will incur additional administrative costs for managing a larger ESRD population.

CMS has responded to the 21st Century Cures Act with several proposed changes in the 2021 Advance Notice Part II and the February 6, 2020 Memorandum "Contract Year 2021 Part C Benefits Review and Evaluation." These proposals are to:

- Change the data used to set the mandatory Maximum Out-of-Pocket (MOOP) limits to reflect out-of-pocket expenditures of all MA beneficiaries, including ESRD. The MOOP for 2021 will be $7,550 which is a significant increase over the 2020 value of $6,700. It is important to note that the new level does not account for 100% of ESRD costs. Had CMS included the entire year over year difference due to including ESRD data, the MOOP would be $8,174.
- Increase the Total Beneficiary Cost (TBC) threshold by $1.00 to $37.00 PMPM for 2021. This increase is directly related to the increase in the mandatory MOOP, which increases the average beneficiary cost.

As discussed above, the Act also prescribed that organ acquisition costs for kidney transplants be excluded from determination of the MA benchmark. In addition, MA plans will not be responsible for kidney acquisition costs (KAC) nor organ donor expenses. CMS also stated it will publish a file with key components of the ESRD rate development. Historically, CMS has not published a buildup of the ESRD payment rates as it does for the MA payment rates (risk file). This added layer of transparency will be helpful for projecting rates forward to future years.

Analysis

As we stated above, the historical MLR for an ESRD population is materially higher than the general enrollment population. We evaluated several years of Wakely client bid data and publicly available nationwide bid data to identify the difference in reported MLR experience between ESRD and non-ESRD members. We found the average ESRD MLR was well above 100%, and was about 27 percentage points above the non-ESRD MLR.

If average ESRD penetration in MA plans moved to our estimated maximum of 2.5% at the current MLR, member premiums would have to increase by about $18 PMPM or benefits would have to be pared back by a similar magnitude.

Table 7 displays the impact of the incremental increased ESRD MA enrollment on member premium at current MLR and benefit levels. We found that the total premium would have to increase by about $4.60 PMPM for each 0.46% change in ESRD members as a percent of total enrollment.

Table 7 – Required Premium Change

ESRD % of Total MA Enrollment	Premium Increase at Current MLR
0.67%	$0.00
1.13%	$4.63
1.59%	$9.18
2.05%	$13.78
2.51%	$18.43

We believe there are several likely causes of the significantly higher MLR for ESRD members.

First, we believe medical management efficiencies MAOs have been able to achieve for non-ESRD enrollees are more difficult to replicate for ESRD beneficiaries with Dialysis status. The dialysis provider market is heavily concentrated with two main providers – about 70% of all dialysis centers are owned by DaVita and Fresenius[4]. This environment implies Dialysis providers have significant leverage in contract negotiations and that MAOs may struggle to achieve reimbursement rates comparable to FFS levels. Higher MA dialysis reimbursement levels put more stress on plans' ability to achieve costs comparable to Medicare FFS.

In the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule, which was published February 5, 2020, CMS proposed a few changes relevant to network adequacy requirements for ESRD beneficiaries. Specifically, CMS is soliciting feedback on the following:

1. Whether CMS should remove outpatient dialysis from the list of facility types for which MA plans need to meet time and distance standards;
2. Allowing plans to attest to providing medically necessary dialysis services in its contract application (as is current practice for DME, home health, and transplant services) instead of requiring each MA plan to meet time and distance standards for providers of these services;
3. Allowing exceptions to time and distance standards if a plan is instead covering home dialysis for all enrollees who need these services;
4. Customizing time and distance standards for dialysis facilities.

[4] Milliman, December 2019, Medicare Advantage: Eight Critical considerations for every organization as ESRD expands eligibility in 2021, p.3, from https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicare-advantage-eight-critical-considerations.ashx

The above proposed changes would relax network adequacy requirements for dialysis related services and potentially facilitate increased provider competition to perform these types of services.

Second, the payment does not account for the large potential impact of a MOOP limit that is required of all MA plans. Third, the use of a statewide average dialysis payment can create challenges in counties where costs exceed the state average.

Impact of FFS Costs not Reflecting a MOOP Provision

The Part C benchmark calculation is based on the cost of benefits in Original Medicare, which do not include a cap on beneficiary cost sharing. Under MA, all plans must include a MOOP equal or less than the "Mandatory" MOOP. Given the cost of dialysis treatment, a beneficiary receiving dialysis treatment is much more likely than a non-ESRD beneficiary to hit a cap on member out of pocket costs. In reviewing the 2018 member level spend in the LDS, we found that about 79% of all ESRD beneficiaries in Original Medicare have out-of-pocket costs exceeding the MA mandatory MOOP level of $6,700.

As noted above, CMS is proposing a mandatory MOOP of $7,550 for 2021. Although CMS has proposed a higher MOOP to account for this potential additional expense, our analysis shows that the increase would have little impact on addressing the cost effects of increased ESRD beneficiary enrollment in MA. Based on our analysis of the 2018 LDS, imposing a $6,700 MOOP would increase costs per FFS beneficiary by 9.2% relative to no MOOP. Our analysis further suggests that increasing the MOOP by $850 to $7,550, as CMS has proposed for 2021, would only lower these beneficiary costs by 1 percentage point. The increased costs to the Medicare FFS program from applying a $7,550 MOOP would still be 8.2%.

To estimate the potential impact, we modeled adding a MOOP to Original Medicare. We analyzed the 2018 LDS costs pre and post MOOP and found the difference – which illustrates the difference between the Part C benchmarks and expected costs under an MA plan with a MOOP – is much greater for ESRD dialysis beneficiaries than for non-ESRD beneficiaries.

Table 8 shows the spending PMPM and percentage impact of various MOOP levels. For a non-ESRD population we estimate that the Original Medicare spending PMPM assuming no MOOP increases by 2.9%, from $831 to $855, when a $6,700 MOOP applies. Our analysis shows that this impact triples in size for an ESRD population, where spending PMPM increases from $7,221 to $7,883 (or 9.2%). The proposed increase in the mandatory MOOP from $6,700 to $7,550 would have a minor impact on the spending PMPM. For a non-ESRD population, the higher MOOP results in a net spending PMPM decrease of 0.4% to 2.5%. The same MOOP change for the ESRD population results in

a decrease of about 1.0% to 8.2%. In other words, applying a $7,550 MOOP in Original Medicare would increase Medicare spending PMPM by 8.2% relative to applying no MOOP – this scenario illustrates the additional cost borne by MA plans due to the MOOP.

Table 8 – Estimated LDS FFS Costs by MOOP Level

Measure	Population	MOOP Level None	$3,450	$6,700	$7,550
Estimated LDS Spending PMPM	Non-ESRD	$831	$877	$855	$852
	ESRD	$7,221	$8,173	$7,883	$7,813
% Change vs. No MOOP	Non-ESRD		5.5%	2.9%	2.5%
	ESRD		13.2%	9.2%	8.2%

CMS also proposed to increase the TBC threshold from $36.00 PMPM to $37.00 PMPM in 2021 to account for the increase in the MOOP limit. We tested the proposed CMS TBC change to evaluate how the $1 TBC threshold increase compares with the increase in members' out-of-pocket expenses if the mandatory MOOP limit is increased by $850 to $7,550. For plans that already apply the mandatory MOOP limit of $6,700, only one of the plans had a change in out-of-pocket cost (OOPC) value less than $1. The majority of the plans had an OOPC change ranging from $1.10 to $1.91. Therefore, for plans with a current MOOP limit of $6,700, our analysis shows the $1 increase in the TBC threshold may not be enough to cover the impact of increasing the MOOP to the $7,550 level.

Based on nationwide 2019 PBPs, the majority of MA plans (about 60% nationwide) have a mandatory MOOP less than $6,700 and greater than voluntary MOOP amount of $3,400. Including these plans in our analysis, and increasing the MOOP levels they apply by $850 (the same absolute increase in the mandatory MOOP level), we saw the OOPC change is about double that of a plan moving from $6,700 to $7,550. Having a lower MOOP means a higher percentage of beneficiaries are going to hit the limit, which is why the OOPC change gets amplified. The increase in the TBC threshold would therefore need to be even higher to account for plans with MOOP levels below the mandatory limit of $6,700 increasing their MOOP levels by $850 for 2021.

Use of Statewide Average Dialysis Payment Rates

For beneficiaries in dialysis status, MA plans are paid based on statewide average ESRD benchmarks. We observed in the 2018 LDS that total spend for ESRD beneficiaries can vary significantly within a state; although, it is important to note that costs at the county level may not be fully credible in counties with a small number of ESRD beneficiaries with Dialysis status. This means individual counties experience ESRD FFS costs that exceed the MA payment rate. We sorted the counties from the January 2020 MA penetration files published by CMS based on MA enrollees, and looked at the top fifteen counties. Of the

fifteen counties, eleven had costs that exceeded the ESRD payment rate with Cost/Payment ratios ranging from 101.9% in Maricopa, AZ to 136.5% in Kings County, NY. Table 9 displays these fifteen counties and their 2018 Cost/Payment ratio.

Table 9 – Comparison of 2018 FFS Cost/Payment Ratios

State	County	January 2020 MA Enrollment	January 2020 MA Penetration Rate	2018 ESRD Dialysis Cost/Payment
CA	Los Angeles	1,603,769	48.3%	114.4%
FL	Miami-Dade	503,439	66.7%	114.9%
AZ	Maricopa	762,339	42.0%	101.9%
TX	Harris	599,681	46.2%	118.4%
CA	Orange	549,680	48.7%	92.6%
CA	San Diego	575,361	46.0%	93.4%
IL	Cook	882,163	29.9%	121.9%
CA	Riverside	421,808	53.3%	93.5%
FL	Broward	363,232	52.7%	123.6%
CA	San Bernardino	333,539	55.7%	123.5%
NY	Queens	398,172	45.9%	127.0%
NY	Kings	407,537	43.0%	136.5%
PA	Allegheny	279,175	60.0%	110.2%
NV	Clark	398,628	41.4%	97.2%
MI	Wayne	354,164	45.9%	114.5%

In conclusion, there is evidence which suggests the current ESRD payment system is not adequate to cover the high costs generated by ESRD members. Although CMS has proposed changes to limit the burden on plans, while simultaneously increasing the burden on MA beneficiaries, our analyses show it may not be sufficient to offset the potential increase in premiums and/or decrease in benefits.

Part C Risk Adjustment Model for CY 2021 and Analysis of the FFS Normalization Factor

Part I of the Advance Notice, released January 6, 2020, proposed that the 2017 CMS-HCC RAPS and 2020 CMS-HCC EDS models continue to be used for 2021.

The RAPS/EDS blend is proposed to be 25%/75% for CY 2021, which is consistent with the schedule published in the Final Announcement for CY 2020.

Part C FFS Normalization Factor

The proposed Part C FFS normalization factor for CY 2021 is 1.106/1.097 for the RAPS/EDS models, respectively. This compares with CY 2020 factors of 1.075/1.069.

Table 10 shows the impact of changes to FFS normalization factors on plan payments over the last few years (assuming no change in plan risk scores).

Table 10 – Change in Part C FFS Normalization Factors

Contract Year	FFS Normalization		Year over Year Payment Impact	
	RAPS	EDS	RAPS	EDS
2018	1.017			
2019	1.041		-2.3%	
2020	1.075	1.069	-3.2%	
2021	1.106	1.097	-2.8%	-2.6%

Although CMS did not provide quantitative analysis in support of the normalization factor, it did say it believes that the increase in the FFS normalization factor may be driven by the following:

- Changes in demographics,
- Change in reported health status in the FFS population,
- Implementation of ICD-10 diagnoses, and
- An incentive to report diagnosis codes more completely in alternative payment models.

Mathematically, the year-over-year change in FFS normalization factors are driven by two things:

1. The restated and updated trend amounts which are derived from a five-year rolling average. For CY 2020, the average trend was 1.46% calculated from risk scores for years 2014 through 2018. For CY 2021, the average trend published by CMS in the Advance Notice was 1.70% and uses risk scores for years 2015 through 2019.
2. The years of trend between the denominator year and the payment year. For both payment years, the denominator year is 2015; therefore, there are 5 years of trend for CY 2020 and 6 years of trend for CY 2021.

The impact of changing the years underlying the five-year average has been significant in the past few years due to a spike in risk scores in 2016. In the final notice for CY 2018, CMS published a graph which illustrated their estimates of future year scores. The graph showed not only a large increase from 2015 to 2016, but it showed that trend continuing in the proceeding years. Table 11 displays the CMS published risk scores used to calculate the FFS Normalization factor in CY 2020 and CY 2021.

In order to better understand the CMS analysis, Wakely calculated average risk scores for payment years 2014 through 2018 using 2013 through 2018 LDS data on FFS beneficiaries. Because LDS only represents a 5% sample, the aggregate scores do not tie exactly to the CMS published values; however, the trends produced from the LDS output are about 0.5% lower than what has been published by CMS. Table 11 displays the Wakely calculated risk scores from LDS along with the implied trend and 2020 FFS Normalization Factor. The difference between the 1.075 and the 1.051 is concerning, and we believe further studies should be done to confirm the 1.075 is appropriate.

Table 11 CMS Published Risk Scores by Year

Year	2020 Final Notice	2021 Advance Notice	Wakely Calculated from LDS
2014	0.999	N/A	0.978
2015	1.000	1.001	0.980
2016	1.021	1.021	1.001
2017	1.034	1.035	1.012
2018	1.055	1.054	1.018
2019	NA	1.069	N/A
Average Trend	1.46%	1.70%	0.99%
Years of trend (denominator to payment year)	5	6	5
FFS Normalization Factor	1.075	1.106	1.051

Changes in Demographics

CMS stated in the 2018 Final Notice, that the increase in trend was partly driven by a smaller proportion of new enrollees in 2016 than in 2015 and a higher proportion of community enrollees. The 2017 HCC model uses eight different models:

- Community Non-Dual Aged
- Community Non-Dual Disabled
- Community Full Benefit Dual Aged
- Community Full Benefit Dual Disabled
- Community Partial Benefit Dual Aged
- Community Partial Benefit Dual Disabled
- Institutional
- New enrollee

Table 12 displays the distribution of member months on the community, new enrollee and institutional models. While, the distribution has slowly shifted between community and new enrollee over time, it is not a dramatic change.

Table 12 – LDS Distribution of FFS Enrollment by Risk Model

Year	Community	New Enrollee	Institutional
2012	83.60%	11.88%	4.53%
2013	83.68%	11.98%	4.34%
2014	84.52%	11.75%	3.73%
2015	84.73%	11.64%	3.63%
2016	84.73%	11.77%	3.50%
2017	85.04%	11.54%	3.42%
2018	85.32%	11.33%	3.35%

Focusing just on the Community and New Enrollee beneficiaries and risk scores, we see an overall increase in the Community model scores; however, New Enrollee scores have stayed relatively steady. Table 13 compares combined risk score trends using the actual distribution of Community and New Enrollee beneficiaries in each year with scores based on a fixed distribution from 2014. The actual combined Community and New Enrollee risk scores have an average trend of 1.0%, which is slightly higher than the average trend of 0.96% if the 2014 risk score

distribution was held constant, due to growth in the Community risk scores over time. Although the Community model scores are higher than the New Enrollee model scores, the shifts in distribution by year do not have a material impact on the overall trends.

Table 13 – Comparison of Combined Community and New Enrollee Scores with Dynamic versus Fixed Distribution

Year	Community	New Enrollee	Combined Risk Score	Combined Risk Score with Static (2014) Distribution
2014	87.80%	12.20%	0.9414	0.9414
2015	87.90%	12.10%	0.9443	0.9439
2016	87.80%	12.20%	0.9654	0.9654
2017	88.10%	11.90%	0.9759	0.9752
2018	88.30%	11.70%	0.9814	0.9800
Average Trend			1.00%	0.96%

Changes in Reported Health Status

CMS has also stated that changes in reported health status are a contributing factor to the increase in FFS normalization factor. It is not clear how CMS defines "health status". As a proxy for health status, we looked at the proportion of aged vs disabled enrollees. The 2017 CMS-HCC model defines all beneficiaries under the age of 65 as disabled, therefore, anyone 65+ is scored on the aged models. However, if a beneficiary is 65+ and has an original reason of entitlement indicator as anything other than age-in, the beneficiary will receive an additive increase in their score for being disabled. In the Non-Dual Community aged model, which is the majority of enrollees, females over the age of 65 with disability status receive a +0.244 increase and males receive a +0.152 increase in risk score.

The percentage of 65+ beneficiaries with disability status is increasing over time. In addition, the year over year change in 65+ females with disability status is increasing at a higher rate than males. Given, the significant difference in the demographic weight for female and male, it is clear that this statistic is having a material impact on the overall trend. Table 14 shows the female and male annual changes. However, this trend alone cannot explain the sustained growth in FFS risk scores estimated by CMS.

Table 14 – Annual Change in Percentage of LDS Enrollees Classified as Originally Disabled

Year	Yearly Increase in Females 65+ Originally Disabled	Yearly Increase in Males 65+ Originally Disabled
2013	2.80%	2.80%
2014	2.20%	1.80%
2015	2.80%	3.10%
2016	3.40%	3.10%
2017	2.00%	1.30%
2018	1.70%	0.90%

Participation in Alternative Payment Models

We also considered CMS's explanation that increasing risk score trend may be partly due to "an incentive to report diagnosis codes more completely in alternative payment models (which are increasing in penetration)". To examine this theory, we analyzed how LDS risk scores vary with the percentage of beneficiaries assigned to Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Programs (MSSP) by county. We used ACO beneficiary participant counts from published CMS public use files.[5]

Based on the MSSP beneficiary participation data, there is dramatic increase from 2016 to 2017; however, the risk score trend from 2016 to 2017 does not differ from previous years. The annual trend is also not unusually high for payment year 2018, which would be the first year where diagnoses would have been submitted by a much greater number of ACOs participating in MSSP the prior year. Table 16 shows these results.

[5] See for example, https://data.cms.gov/browse?category=Special%20Programs%2FInitiatives%20-%20Medicare%20Shared%20Savings%20Program%20(MSSP)

Table 16 – LDS Risk Scores by Payment Year and MSSP Participation

Payment Year	MSSP Participants as % of Total	2017 CMS-HCC Risk Score	Annual Trend
2018	26%	1.018	0.6%
2017	23%	1.012	1.0%
2016	4%	1.001	2.1%
2015	3%	0.980	0.2%
2014	2%	0.978	
2014-2016			1.2%

We further analyzed risk scores by grouping counties with at least 25% of beneficiaries assigned to an ACO participating in MSSP. We compared results for counties where the MSSP participation changed from below 25% to 25% or more in either 2016 or 2017. We also looked at counties where the participation rate was below 25% in all years or 25% or more in all years. Table 17 shows these results.

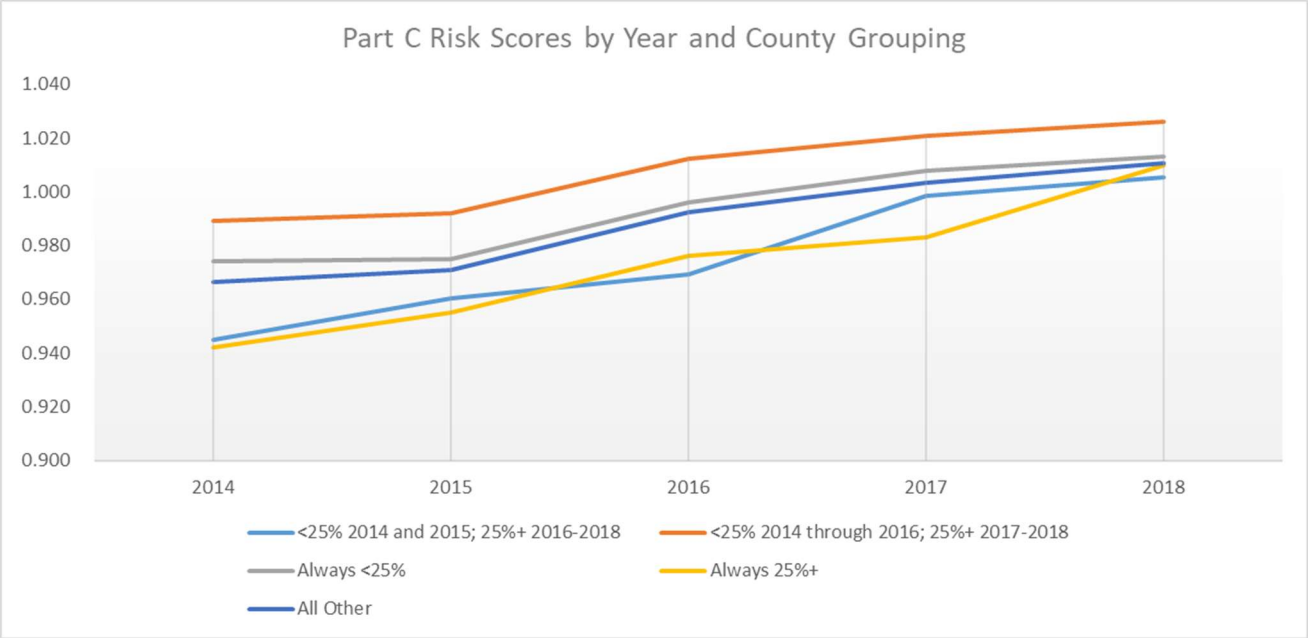
Table 17 - LDS Risk Scores by Payment Year and County Groupings of MSSP Participation

Payment Year	<25% 2014 and 2015; 25%+ in 2016-2018	<25% 2014 through 2016; 25%+ 2017-2018	Always <25%	Always 25%+
2018	1.006	1.026	1.013	1.010
2017	0.999	1.021	1.008	0.983
2016	0.969	1.013	0.996	0.976
2015	0.960	0.992	0.975	0.955
2014	0.945	0.989	0.974	0.942
2014-2018	1.5%	0.9%	1.0%	1.7%

Table 17 shows that the risk score trend over 2014 to 2018 is highest for counties where beneficiary participation in MSSP was 25% or more in all years. The average trends are also higher than average for counties that saw participation below 25% in 2014 through 2016, followed by 25% or more in both 2017 and 2018. Cutting off the <25%/25%+ year at 2017 rather than 2016 does not yield similar results, however. It is also interesting to note that absolute scores for counties that saw participation below 25% in all years were higher than all other groupings besides

the 2014-2016 versus 2017-2018 grouping. This analysis further suggests growth in beneficiary participation in alternative payment models is not clearly leading to FFS risk score growth.

The graph below compares risk scores by payment year for the different cohorts presented in Table 17, as well as a "catch-all" grouping of counties that did not meet any of the specified criteria.



Overall, our analysis of risk scores as they relate to MSSP participation does not point to a clear conclusion. The trends in risk scores for the different categories are generally similar, and do not indicate any one category has experienced dramatically different trends in scores over 2014 through 2018. This analysis does highlight that the absolute scores vary, with the <25% 2014-2016; 25%+ 2017-2018 group showing the highest scores and the "Always 25%" group generally showing the lowest scores.

It is important to note that our analysis is not statistically rigorous. A regression study would be the most appropriate approach; however, such a study is beyond the scope of this report.

Appendix A – Method and Assumptions

CMS Part C Benchmarks

The Part C benchmark analysis uses publicly available data published by CMS.

- The 2021 benchmark projections use the information and methodology presented in file *CalculationData2020.xlsx* trended forward by the growth rates provided in the Advance Notice.
- We summarized nationwide data using the January 2020 MA county level enrollment file and published star rating data to be used for payments years 2020 and 2021.
- Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing for 2021.

FFS Normalization Analysis

The Wakely analysis of CMS FFS normalization factors and the related risk score trends is based on FFS beneficiaries in the CMS Limited Data Set (LDS) over 2013 through 2018. Wakely scored beneficiaries using the prior year diagnoses and the 2017 CMS-HCC risk adjustment model.

For enrollment years 2012 through 2015, LDS did not have an indicator to differentiate partial benefit duals from full benefit duals. To estimate the mix between partial and full benefit duals on both the aged and disabled models, we calculated the average mix at a state level for 2016 and 2017. The state level full benefit/partial benefit mix was then applied to individual member scores (i.e. each member received a weighted average score of the different models).

As mentioned in the body of the report, it is an important caveat that we were not able to tie to CMS's published risk scores or trend values. This is likely due to inconsistencies between the 5% sample and the 100% data set.

Risk score trends in our analysis are calculated by calculating the slope of the 5 year trend line. For example, the underlying trend of 1.46% in the 2021 FFS Normalization factor was calculated by the change in the risk scores from 2015 through 2019 (1.069 – 1.001 = 0.068) divided by the change in years (2019 – 2015 = 4) equating 1.70%.

For the analysis where we analyzed risk scores by groupings of counties depending on the FFS beneficiary assignment to ACOs participating in MSSP, we relied on CMS published enrollment from the "Number of ACO Assigned Beneficiaries by County" public use files. In determining the percentage participation by county, we used Part A FFS enrollment as the total.

ESRD Analysis

Calculation of MLR

We evaluated 2013 Nationwide BPT data, published by CMS, together with Wakely client data in bids filed over 2018 through 2020. The average MLR was calculated by using WS1 data and taking an average across the multiple data sources.

Required Premium Change

To calculate the required premium change as the ESRD mix increases, we used the same claims and revenue data as described in the MLR calculation above. In each iteration we recalculated what the new margin would be as more ESRD members were added to the mix. Then, we were able to back into the required premium increase assuming the same margin levels as the baseline ESRD mix scenario (i.e. ESRD members as 0.67% of total).

MOOP Impact

The MOOP impact is a multi-step process. The results displayed in Table 6 rely on data from the 2018 LDS. First we identified which ESRD beneficiaries had transplant status monthly, by using several procedure codes in the inpatient data tables. Next, we identified which ESRD beneficiaries received dialysis by month. (Dialysis makes up the majority of the ESRD population.) Transplant status is effective from the date of transplant to three months after. Beginning in the fourth month post-transplant, a member moves to Functioning Graft, as long as the member has not returned to dialysis. If the member receives dialysis at any time after the transplant they revert back to Dialysis payment status.

Once we had a unique list of members with status, we pulled claims separately for each of the statuses and calculated the impact on the paid amounts with a MOOP implemented, based on original Medicare benefit cost sharing provisions.