



**Matthew Eyles**  
President & Chief Executive Officer

April 6, 2020

Ms. Seema Verma, Administrator  
Centers for Medicare & Medicaid Services (CMS)  
Attention: CMS-4190-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**RE: 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 (“Proposed Rule”)**

Dear Administrator Verma:

America's Health Insurance Plans (AHIP)<sup>1</sup> appreciates the opportunity to comment on the Proposed Rule. As we submit these comments in the middle of the COVID-19 pandemic, a public health emergency that is unprecedented in its scale and impact, we sincerely hope that you and the entire CMS team are safe, healthy, and well. This crisis is subjecting all sectors of the country to unforeseen and extraordinary challenges. We commend you, the CMS leadership team, and the CMS staff for the tireless work across the agency and the steps that CMS has already taken to expand flexibility and reduce unnecessary burdens on doctors, hospitals, health insurance providers, and other stakeholders so they can best focus on responding to the challenges.

Enormous uncertainties about the scope, cost, duration, and ultimate impact of the COVID-19 crisis remain that could have significant and unforeseen effects on the Medicare Advantage (MA) and Part D programs in 2021. We have separately provided CMS with recommendations on ways to further revise program requirements and address actuarial uncertainties that are affecting both current 2020 operations and the ability of MA and Part D plans to prepare bids for the 2021 plan year. These changes are essential to ensuring program stability for enrollees, providers, taxpayers, and other affected parties. We urge the agency to act swiftly to address MA plan issues that are critical to ensure the delivery of optimal and stable plan benefits and timely and effective communications and information flow. Our comments here will focus on the MA and Part D proposals in the Proposed Rule, although we will highlight COVID-19-specific issues where particularly relevant.

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<sup>1</sup> AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day, including those enrolled in Medicare Advantage (MA), Medicare Part D, Medicaid, and PACE. 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.

## **The Value of MA and Part D, and Policy Proposals That Will Enhance Their Value**

*The Value of Medicare Advantage and Part D.* The MA and Part D programs are models of consumer choice, competition, and innovation that help deliver high-quality, affordable coverage and care to tens of millions of Americans. More than 24 million people – 35% of those eligible for Medicare – are now enrolled in MA, and the program continues to grow dramatically year by year. Moreover, 47 million Americans are enrolled in Part D, a program that has been a model of consumer choice and market competition and has improved access to prescription drugs while reducing out-of-pocket costs.

Seniors and people with disabilities increasingly choose MA over the traditional Medicare program and consistently indicate high satisfaction rates.<sup>2</sup> MA plans work with members to prevent, detect, and manage chronic conditions. MA plans offer more comprehensive types of benefits and services, including telehealth and benefits such as nutrition, transportation, and in-home services, which help address various social barriers to better health. Furthermore, plans offer more financial security than traditional Medicare by capping enrollee annual out-of-pocket costs and in many cases providing drug coverage for no additional cost.<sup>3</sup> MA plans outperform traditional Medicare on clinical quality measures<sup>4</sup>, survival rates<sup>5</sup>, hospital readmissions and patient days spent in rehabilitation facilities and nursing homes<sup>6,7</sup>, and hospital use in the last days of life.<sup>8</sup> A newly released study concluded that MA enrollees with Alzheimer disease and related dementias had lower rates of health care utilization than traditional Medicare beneficiaries without compromising care satisfaction or health status, suggesting MA plans may be more efficient at delivering care for this patient population.<sup>9</sup>

In this regard, MA is not only a good deal for seniors; it is cost effective for taxpayers. Plan bids for delivering the basic Medicare benefit have been well below traditional Medicare costs for several years and are now 88% of traditional Medicare costs, based on the latest Medicare Payment Advisory Commission (MedPAC) estimates. Further, according to MedPAC, average payments to MA plans in

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<sup>2</sup> A recent survey finds 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. Morning Consult National Poll. December 10-17, 2019. Available online at: <https://medicarechoices.org/americans-like-ma/>

<sup>3</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. March 2020.

<sup>4</sup> 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.

<sup>5</sup> Mandal, Alope 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.

<sup>6</sup> 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. *PLoS Med* 15(6): e1002592.

<sup>7</sup> 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.

<sup>8</sup> 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.

<sup>9</sup> Park, S., White, L., Fishman, P. Medicare Advantage and traditional Medicare beneficiaries with and without Alzheimer disease and related dementias. *JAMA Network Open* 3(3): e201809. March 2020.

2020 are equivalent to traditional Medicare costs – and have been since 2017 – while offering supplemental benefits and enhanced financial security for seniors.<sup>10</sup> 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.<sup>11</sup>

*Policies That Enhance the Value of MA and Part D.* AHIP encourages policies that expand flexibility, choice, competition, and value in MA and Part D because these programs are critical to achieving national policy goals for improved health care. CMS has taken numerous steps in recent years to strengthen MA and Part D. They include adding new benefit flexibilities and reducing certain unnecessary administrative burdens. We commend CMS for those actions, and for including a number of policies in the Proposed Rule that will further support the delivery of better care and better value through innovative, patient-centered programs that improve quality and reduce costs for seniors and others eligible for Medicare. For example:

- **Flexibility in Dialysis Care Delivery.** We strongly support certain proposals that CMS is considering to enhance MA plan flexibility in network adequacy standards for dialysis facilities. The flexibility would promote innovation, increase access, and reduce costs for people with end-stage renal disease (ESRD). AHIP has consistently raised serious concerns about the negative effects of consolidation among dialysis providers. The Administration has been a leader in taking steps to encourage more Americans to obtain treatment outside dialysis centers through home dialysis and other alternative delivery methods, including through Innovation Center models designed to overhaul the delivery of kidney care. These steps are even more important given the COVID-19 public health emergency. COVID-19 highlights the vulnerabilities of people with serious illness and/or a compromised immune system, and the need to have a viable treatment infrastructure that allows them to access life-saving dialysis services while protecting them from exposure to infection. Although MA plans already employ new ways to improve health and outcomes for people with ESRD, advancements in dialysis technology combined with more flexible network standards can ensure patient protections while helping MA plans further deliver on the goals articulated in the Administration’s Advancing American Kidney Health Initiative.
- **Flexibility to Expand Telehealth and Rural Access and Address Anti-Competitive State Laws.** CMS is proposing network flexibility to increase competition and access for enrollees using emerging telehealth technologies, as well as for those living in rural areas. These flexibilities would also address anti-competitive restrictions like certificate of need laws in certain states. We strongly support these steps. The COVID-19 pandemic also reinforces the need for CMS to continue exploring additional flexibilities that promote innovative ways for patients to access medical services when traditional time and distance standards may not be an appropriate means of measuring access to care.

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<sup>10</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. March 2020.

<sup>11</sup> 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.

- **Expanded Negotiating Tools in Part D.** CMS' proposal to expand private-sector negotiating tools in Part D by allowing a second "specialty" tier will help to expand competition among manufacturers. Greater competition will allow plans to obtain larger price savings from manufacturers and encourage Part D enrollees to use more cost-effective drugs. The result will be lower patient cost-sharing and lower beneficiary premiums, savings for plan customers like employers and states, and reduced costs for taxpayers.
- **Encouragement of Supplemental Benefits.** We commend CMS for a proposed regulatory change that will ensure all amounts paid for covered services, including expanded supplemental benefits are counted as covered medical expenses for medical loss ratio purposes. The change will enhance the ability of MA plans to offer benefits that address social barriers to care and other needs of chronically ill enrollees.

### **Policy Proposals That Would Limit Choice and Innovation and Diminish Program Value**

We are concerned that several proposals in the Proposed Rule are inconsistent with the goals of the MA program because they could undermine choice, benefits, and costs for Americans and diminish the value of the program.

- **Limits on Certain MA Plans Attractive to Dually Eligible Enrollees.** A proposal to eliminate certain MA plans that enroll a significant number of individuals dually eligible for Medicare and Medicaid could disrupt their care and prevent them from accessing coverage that may best meet their needs. "Partial dual eligibles" – people who receive help paying Medicare premiums and cost-sharing but not the full array of Medicaid benefits – could lose access to benefits not otherwise available to them. While we strongly support enhanced integration of Medicare and Medicaid benefits for dual eligibles and appreciate CMS' goal to encourage more integration, we believe the proposal would have adverse, unintended consequences. We urge CMS to explore more flexible approaches.
- **Cut Point Changes for Star Ratings.** We have significant concerns with CMS' proposal to exclude performance "outliers" when setting cut points for certain Star Ratings measures. We believe there are flaws in the proposed methodology. Moreover, the magnitude of reductions in Star Ratings would adversely affect premiums and supplemental benefits; an analysis by Wakely Consulting Group<sup>12</sup> found that CMS may have significantly underestimated such negative impacts.<sup>13</sup> Nearly one-quarter of MA contracts could have their performance reduced by 0.5 Stars as a result of the methodology change. We appreciate CMS' desire to increase predictability and stability of cut points, but we continue to urge the agency to reinstate the policy that will best achieve those objectives: predetermined cut points in advance of the measurement period.

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<sup>12</sup> Wakely Consulting Group. Proposed Rule Changes to the Medicare Star Rating Program: Analyzing the Impact of Proposed Changes on Medicare Advantage Spending. March 2020.

<sup>13</sup> Reductions relating to 2024 MA spending (based on 2023 Star Ratings) are estimated to be \$1.4 billion, which is nearly 2 times more than CMS estimated.

- **Emphasis of Survey Data Over Clinical Outcomes in Star Ratings.** We have significant concerns with a proposal to change the Star Ratings program by increasing the weight of patient experience/complaints and access measures relative to other measures. These measures are based on a limited sample that may yield inaccurate, unreliable, or biased data, which will be further affected by extraordinary events like the COVID-19 public health emergency. Overweighting survey or administrative data compared to clinical outcomes does not align with CMS' guiding principles for the Star Ratings program, which include focusing on measures that are developed by consensus-based organizations; that treat contracts fairly and equally; that are based on accurate, complete, and reliable data; and that are subject to improvement based on factors under a plan's control. An analysis by Wakely found significant year-over-year volatility in average Star Ratings for these measures despite consistent trends in plan performance over time. Increasing the weights for these measures has the potential to erode the integrity of the Star Ratings program – by basing the majority of the Star Rating score on such measures where the correlation between average contract performance and Star Ratings is unclear.<sup>14</sup> Finally, while CMS indicates that this change would actually have a positive impact on Star Ratings, Wakely also found that the impact on MA spending in the first affected year, 2024, would be minimal – and nearly 5 times less than CMS estimated.<sup>15</sup> When combined with the proposal to exclude outliers, more MA enrollees would be in plans negatively impacted than those who would see positive results.
- **Calculation of Certain ESRD Costs Excluded from MA Benchmarks.** We remain concerned with the methodology CMS proposes to exclude organ acquisition costs for kidney transplant from MA benchmarks. The magnitude of the cost carve-outs and the resulting impacts on premiums and benefits could be very significant in many urban areas. Given the potential impacts on all MA enrollees, we reiterate the request in our comments on the CY 2021 Advance Notice that CMS provide more transparency regarding the calculation of the carve-out factors.

## Timelines

As noted in our comments on the Advance Notice, several policies in the Proposed Rule would have important impacts on the costs and/or benefits available to MA and Part D enrollees in 2021. Given the late release of CMS' rulemaking for 2021, we remain concerned about the uncertainty affecting plans that attempt to incorporate changes into projected costs or benefit designs for 2021 bids, which are due June 1, 2020. The COVID-19 crisis has obviously injected even more uncertainty into the bid process.

Therefore, to the extent CMS moves forward with the Proposed Rule, we ask CMS to finalize all proposals with significant impacts on 2021 benefits that AHIP and its member plans support as quickly as possible separately from other parts of the Proposed Rule. At the same time, *in recognition of the current environment, we ask CMS to consider making all new 2021 obligations*

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<sup>14</sup> Wakely Consulting Group. Star Rating Variability of Patient Experience and Access Measures: Analyzing the Impact of Variable Star Rating Cut Points and Measure Level Results. March 2020.

<sup>15</sup> Wakely used 2020 Star Rating performance data (more recent than 2018 data used by CMS). See: Wakely Consulting Group. Proposed Rule Changes to the Medicare Star Rating Program: Analyzing the Impact of Proposed Changes on Medicare Advantage Spending. March 2020.

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*in the Proposed Rule voluntary rather than mandatory.* The effective date for mandatory compliance could be deferred until 2022. This would help plans limit as much as possible the uncertainties surrounding the bid process. It would also enable them to best focus resources on helping patients and providers in 2020, and supporting implementation of CMS initiatives directed to the COVID-19 emergency.

### **Conclusion**

Again, we appreciate the opportunity to comment on the Proposed Rule and the tremendous efforts across the agency to move the MA and Part D programs forward amidst the unprecedented challenges our nation faces due to COVID-19. Attached are detailed comments on the foregoing proposals and other provisions in the Proposed Rule. Our recommended changes are aimed at maintaining and growing strong and stable MA and Part D programs so millions of seniors and people with disabilities continue to receive the high-quality, coordinated care they deserve and rely on. We look forward to continuing to work together on policies that ensure affordable and innovative choices in MA and Part D to improve the health and well-being of Americans.

Sincerely,

A handwritten signature in cursive script that reads "Matthew Eyles".

Matthew Eyles  
President & Chief Executive Officer

## AHIP Detailed Comments on CMS Proposed Rule

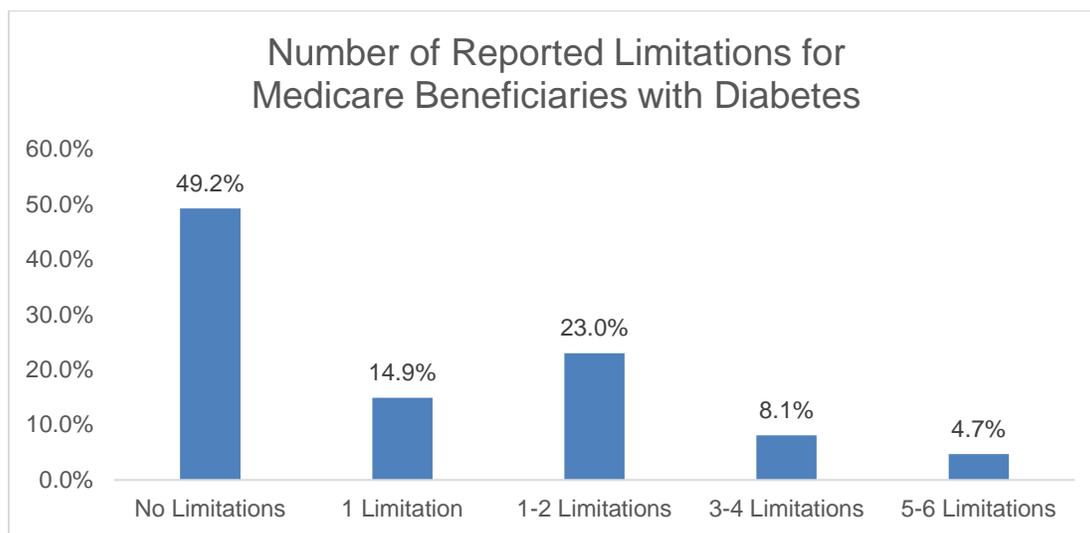
### Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

#### II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

##### A. Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)

CMS proposes to codify in regulation, with some modifications, existing SSBCI sub-regulatory guidance and statutory parameters, including those defining SSBCI and chronic conditions. One of the modifications that CMS proposes to make is to allow plans to cover chronic conditions beyond those included on the list of eligible conditions established by the panel of clinical advisors.

**Recommendation:** AHIP strongly supports the proposed additional flexibility that would enable plans to continue to innovate around providing supplemental benefits for their chronically ill enrollees. There are noted variations in functional status among Medicare beneficiaries with chronic conditions, like diabetes and arthritis, in the literature.<sup>16</sup> For example, as illustrated by the latest Medicare Current Beneficiary Survey (MCBS) data available, nearly half of diabetic beneficiaries report no functional limitations (see chart below).



Source: Analysis of 2017 MCBS Public Use File, Fall panel.

<sup>16</sup> For example, see Stineman, Margaret G., et al. Establishing an approach to activity of daily living and instrumental activity of daily living staging in the United States adult community-dwelling Medicare population. *PM & R: the journal of injury, function, and rehabilitation* 6.11 (2014): 976; Jindai, Kazuaki, et al. Peer reviewed: Multimorbidity and functional limitations among adults 65 or older, NHANES 2005-2012. *Preventing chronic disease* 13 (2016); and Barile, John P., et al. Peer reviewed: Patterns of chronic conditions and their associations with behaviors and quality of life, 2010. *Preventing chronic disease* 12 (2015).

Accordingly, we recommend that CMS enhance the existing flexibility by permitting plans to tailor SSBCI to the functional status of enrollees with a given chronic condition, so plans can provide the most targeted benefits to chronically ill enrollees whose health or overall function could be improved or maintained with SSBCI. We believe this is consistent with Section 1852(a)(3)(D)(ii) of the Social Security Act (the Act), which defines a chronically ill enrollee as a beneficiary with one or more comorbid and medically complex chronic conditions that is either life threatening or significantly limits the overall health or function of the enrollee.

*B. Improvements to Care Management Requirements for Special Needs Plans (SNPs)  
(§ 422.101)*

CMS proposes at §422.101 to extend existing care management requirements for chronic condition special needs plans (C-SNPs) to dual eligible (D-SNPs) and institutional SNPs (I-SNPs). These requirements include: an interdisciplinary care team (IDCT) for each enrollee, face-to-face encounters with each enrollee (in person or via telehealth) at least annually, and a comprehensive initial assessment and annual reassessment, the results of which are addressed in the enrollee's care and service plan. In addition, the SNP's model of care (MOC) would be evaluated annually to assess the degree to which its MOC goals were met, and each MOC element would have to meet a minimum benchmark to receive approval.

**Recommendation:** AHIP supports the proposed standardization of care management requirements across the three SNP types but with some modifications. First, while C-SNP and I-SNP enrollees can be expected to have higher than average levels of acuity, that is not the case with all D-SNP enrollees. When a plan's assessment of a D-SNP enrollee concludes that the enrollee has low acuity and few care needs, this would require only a minimal care plan and not warrant designation of an IDCT. We recommend that CMS revise the proposal to permit some level of plan discretion in this regard. Second, we recommend that the standardized care management requirements be voluntary for the first year, and that CMS engage with plans that voluntarily adopted the care management standardization to identify any problems and challenges with standardization before making the requirement mandatory. We also recommend that CMS refine its proposal in two areas:

- With respect to a D-SNP enrollee receiving managed long-term services and supports (MLTSS) through a Medicaid managed care plan, CMS should encourage the D-SNP IDCT to use best efforts to (i) obtain the enrollee's MLTSS assessment and care/service plan; and (ii) incorporate key MLTSS elements from those sources into the D-SNP MOC. This will help reduce the extent to which enrollees are subjected to duplicate assessments and redundant care planning processes.
- CMS should seek further input on the appropriate methodology to evaluate a D-SNP's success in meeting MOC goals and benchmark scoring. For example, the methodology should account for the effects of churn on MOC execution, as some dual eligibles experience changes in Medicaid eligibility that affects their SNP enrollment. In addition, with respect to full benefit dual eligibles, care management of a full benefit dual eligible enrollee would be more comprehensive and complex than for a partial dual eligible because it would take into account Medicaid benefits and possibly LTSS, which generally are not available to partial dual enrollees. We believe MOC evaluations and scoring should account equitably for the

distinct levels of care management engagement and execution in their application to D-SNPs with different mixes of full and partial dual eligibles.

*E. Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514)*

CMS proposes to impose significant new restrictions on MA plans that are not D-SNPs but that have high proportions of Medicare-Medicaid dual eligible enrollment. CMS calls these plans “D-SNP look-alike” plans. CMS indicates that the plans’ designs tend to attract dual eligible enrollees because they allocate a lower percentage of MA rebate dollars to reducing Medicare cost-sharing (which is paid for by Medicaid) and a higher percentage to supplemental benefits. CMS raises a number of concerns, including that such plans are not subject to the same integration requirements as D-SNPs.

Under the proposal, CMS would not enter into or renew a contract for plan year 2022 with an MA plan that is not a D-SNP in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as a Medicare-Medicaid plan (MMP), if certain dual eligible enrollment thresholds are met. Specifically, the MA plan is subject to the restriction for the following year if the proportion of dually eligible enrollment is either projected in its bid to be 80% or more, or the proportion of dually eligible enrollees actually enrolled in the plan in the January enrollment report of the current year is 80% or more. The actual enrollment prong would only apply to plans active for one or more years and with enrollment equal to or greater than 200. CMS also proposes to establish procedures for transitioning enrollees from D-SNP look-likes to other MA plans.

AHIP has been a strong supporter of enhanced integration of Medicare and Medicaid for dual eligibles and the continued evolution of integrated care delivery options. While we therefore appreciate CMS’ goals in proposing the restrictions on look-alike plans, we have concerns with some of the assumptions underlying the proposal and potential unintended consequences.

**1. Value of benefits and choices in look-alike options.** We are concerned that the proposal does not adequately assess the negative impacts on enrollees who may lose access to plans they have determined best meet their needs. For example, CMS notes that “Most D-SNP look-alike enrollment is in markets that feature numerous other plan choices for beneficiaries.” Rather than support CMS’ proposal, we believe it suggests that people with Medicare and Medicaid who are enrolled in look-alike plans see value in those plans, even when other options are available.

Further, partial duals may see different value in look-alike plans as compared to full-benefit duals, but the proposal does not adequately assess those distinctions. For example, CMS’ analysis about available options does not discuss the extent to which D-SNPs covering partial duals are available in the service areas in which look-alike plans are operating. Further, the preamble references an analysis<sup>17</sup> of D-SNP look-alike plans by MedPAC in its most recent report to Congress. On page 444, the MedPAC analysis states:

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<sup>17</sup> “Promoting integration in dual eligible special needs plans”; Chapter 12, MedPAC Report to Congress, June 2019; accessed at [http://www.medpac.gov/docs/default-source/reports/jun19\\_ch12\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0)

*“...for some partial-benefit dual eligibles, there may nonetheless be an advantage to enrolling in D-SNPs because those plans are more likely than traditional MA plans to offer coverage of dental, hearing, vision, and transportation services. These additional benefits are particularly attractive to the subset of partial-benefit dual eligibles who have their Medicare cost-sharing covered by Medicaid.” (emphasis added)*

This reasoning would apply to look-alike plans as well; such plans can offer partial dual eligibles benefits that may otherwise be unavailable in other plans. CMS' proposal could eliminate these valuable options for a low-income population that has come to rely on them.

The proposal also does not assess the extent to which enrollees who would lose access to look-alike plans would revert to receiving their care and services through the fee-for-service (FFS) environment of Original Medicare. While D-SNPs may offer their dual eligible enrollees higher levels of care management and integration, all MA plans deliver important care management and coordination services, as well as supplemental benefits, not available in the Original Medicare program. These losses are not accounted for in the proposal.

D-SNP look-alike plans appear to be fulfilling a need for dual eligibles, including partial dual eligibles who do not have Medicaid benefits. While the integration available in D-SNPs is an important and valuable benefit, we are concerned that CMS fails to account for the possible loss of other important and valuable benefits. We believe these potential impacts on partial dual eligibles need to be considered before CMS finalizes the proposal.

Lastly, the Medicare program has a core principle of freedom of choice. Medicare beneficiaries choose whether to enroll in Original Medicare or in an MA plan. If they opt for an MA plan, they choose a plan with a mix of benefits, premiums, and cost-sharing best suited to their needs from among the available plans in their service area. MA beneficiaries who enroll in look-alike plans find something attractive in them and have actively chosen to enroll. We are concerned that CMS does not consider how choice itself is an important objective, nor the impacts of limiting choices for the affected population.

**Recommendation:** Unless and until CMS is able to address these concerns more clearly, CMS should permit look-alike plans to continue to operate as an option for Medicare beneficiaries to help ensure that enrollees of such plans continue to have access to the increased levels of care management and supplemental benefits in MA plans. However, if CMS intends to move forward with rulemaking on D-SNP look-alikes, CMS first should perform a more detailed analysis of available options and potential lost benefits caused by the proposal, including a separate assessment of impacts on full and partial dual eligibles, and publish that analysis for notice and comment. CMS should also explain how it has accounted for the value of choice in its proposal. Such information would help stakeholders understand the potential impacts of the proposal and provide more informed comments. Finally, in determining a compliance time frame, CMS should allow at least two years for dual eligible beneficiaries, MA plans, states, and other stakeholders to review policy options, and devise and implement viable alternatives to achieve compliance.

**2. Market distortions.** It is possible that the market dynamics of look-alike plans are driven in part by market distortions such as providers, insurance agents, and brokers steering enrollees into or away

from certain service delivery models, inappropriate or misleading marketing practices, or as a result of beneficiary and provider confusion. The proposed rule does not account for those considerations.

**Recommendation:** CMS should consider targeted measures that would directly address these specific kinds of distortions, rather than implementing broad restrictions on look-alike plans. For example, if patterns of agent/broker or provider steering are implicated, then CMS might consider instituting measures that would reinforce referral to products best suited to the beneficiary's needs. If misleading marketing practices are a root cause, CMS already has a significant body of regulations and program rules it can bring to bear, and we support the proposal to prohibit MA plans from marketing look-alike plans as if they were D-SNPs or are designed for dual eligibles. In addition, to the extent there are concerns with effective care management and coordination of care for full benefit dual eligibles enrolled in look-alike plans, CMS could also consider requiring such plans to notify the state or the appropriate Medicaid managed care plan of members' hospital and SNF admissions and discharges, similar to requirements placed on non-HIDE non-FIDE "care coordination" D-SNPs beginning in 2021.

**3. Availability of alternatives.** The proposed restrictions would apply to look-alike plans in *states* with other more integrated service delivery options. However, in many states – e.g., California, Florida, New York, Ohio, and Texas – D-SNPs, MMPs, and other integrated options are not available in all geographic areas. CMS 2020 SNP Landscape Source Files<sup>18</sup> indicate that 608 counties have no D-SNP available and another 406 counties have only one D-SNP option. Given that Medicare beneficiaries may only enroll in MA plans offered in their county of residence, the current proposal could eliminate an important option for a beneficiary who actually has no integrated option available where he or she lives. Moreover, as noted above, some integrated options might be available only to full benefit dual eligibles, but the proposal does not distinguish between them and partial duals. And in states like those noted above, neither D-SNPs, MMPs, nor other integrated options are available in all counties to any dual eligible individual who might want to enroll.

**Recommendation:** If CMS decides to impose restrictions on D-SNP look-alike plans, we recommend that CMS limit the proposal to plans operating in a *county* where there is a D-SNP or other integrated plan option. Similarly, we believe the 80% determination threshold would be workable, but given that many SNPs operate in multi-county service areas, we recommend that the threshold test should be applied at the county level as well. The final proposal should also account for the specific categories of dual eligibles (e.g., full benefit duals only vs. both full and partial benefit duals) that can enroll in available integrated options in a given county. This would ensure that the superior features of MA plans as compared with the traditional Medicare program, such as enhanced supplemental benefits and care management programs, would be available as options for all dual eligibles.

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<sup>18</sup> Count of D-SNPs by county from 2020 SNP Landscape Source Files (v 10 15 19). Available online at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2020-SNP-Landscape-Source-Files-v-10-15-19.zip>

### **III. Implementation of Several Opioid Provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act**

#### *A. Mandatory Drug Management Programs (DMPs) (§ 423.153)*

Since 2019, Part D sponsors have been permitted to establish drug management programs (DMPs) for potentially at-risk beneficiaries (PARBs). If a beneficiary is determined to be at risk for misuse of prescription drugs a sponsor may limit access to opioids and benzodiazepines to selected prescribers or pharmacies or may create point of sale edits. In the Proposed Rule, CMS notes that the vast majority of sponsors have voluntarily enacted DMPs.<sup>19</sup> CMS is proposing to enact SUPPORT Act Section 2004, which requires sponsors to implement DMPs for plan years beginning January 2022.

**Recommendation:** We support CMS' efforts to curb the opioid crisis and as such, our member plans have often voluntarily implemented DMPs. We encourage CMS to review the detailed comments submitted by our member plans on specific elements of the proposed standards, e.g. requests for clarification around the identification of PARBs. Additionally, we recommend that CMS release any needed technical guidance related to implementation of mandatory DMPs and other SUPPORT Act provisions as early as possible.

#### *E. Eligibility for Medication Therapy Management Programs (MTMPs) (§ 423.153)*

In accordance with the SUPPORT Act Section 6103, CMS proposes that Part D plans would be required to furnish materials in their MTM programs regarding safe disposal of prescription drugs that are controlled substances. CMS specifically proposes that Part D sponsors would be required to provide this information as part of the comprehensive medication review (CMR) or through the quarterly targeted medication reviews (TMRs) or follow up.

**Recommendation:** We support providing information to beneficiaries in MTM programs on safe disposal of drugs. However, we recommend that CMS consider allowing plans to include the information in alternative documents, other than CMR and TMRs, including in the beneficiary enrollment letters. For example, plans may have difficulty reaching beneficiaries after enrollment if they have disenrolled from the plan for any reason, and it would be useful for plans to have more venues to provide this important information.

### **IV. Implementation of Certain Provisions of the 21st Century Cures Act**

#### *C. Exclusion of Kidney Acquisition Costs from Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)*

Pursuant to Section 17006(b) of the 21<sup>st</sup> Century Cures Act, CMS must develop a methodology to exclude the cost of organ acquisition for kidney transplant from the MA benchmarks beginning in

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<sup>19</sup> "...85.9 percent of Part D contracts in calendar year 2019 and 87.2 percent for calendar year 2020 adopted DMPs to address opioid overutilization among their enrollees. Thus, of about 49 million beneficiaries who were enrolled in the Medicare Part D program in 2019, about 48.5 million enrollees (99 percent) were covered under Part D contracts that offered a DMP already." 85 Fed. Reg. 9002, 9025 (Feb. 18, 2020).

2021, when these costs are covered by the FFS Medicare program. CMS describes this process at a high level in the Proposed Rule, but included a more detailed methodology for doing so in the MA 2021 Advance Notice.<sup>20</sup> Under its proposed methodology, CMS would use 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 apply 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 estimates. In the Proposed Rule, CMS estimates the FFS Medicare cost of kidney acquisition at \$2.82 per-member per-month (PMPM) in 2021 – this equates to roughly 8% of the average premium for an MA plan with prescription drug coverage in 2020.<sup>21</sup> This estimate also appears to diverge from the estimates included in the MA 2021 Advance Notice, in which 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.

Wakely Consulting Group (Wakely) analyzed a 5% sample of FFS Medicare claims data from the Limited Data Set (LDS) over the period 2014 to 2018.<sup>22</sup> Wakely found that only 20 of the 82 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

These data also 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.

<sup>20</sup> CMS. 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 II. February 2020.

<sup>21</sup> Jacobson, G., Freed, M., Damico, A., Neuman, T. Medicare Advantage 2020 spotlight: First look. Kaiser Family Foundation. October 2019. Available online at: <https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/>

<sup>22</sup> Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: <https://www.ahip.org/2021-medicare-advantage-advance-notice/>

**Recommendation:** Historically CMS has released detailed data with annual FFS Medicare proposed rules as well as (albeit to a lesser degree) the annual MA Advance Notice and Final Announcement.<sup>23</sup> We request that CMS release similar information to allow for appropriate notice-and-comment regarding the methodologies for the underlying cost and discharge data used to calculate the kidney acquisition costs in determining the carve-out factors, and to explain why the estimates in the Proposed Rule differ from those in the Advance Notice. Furthermore, we request the detailed data and analyses CMS relied on to determine that county-level data is credible for the purpose of determining the kidney acquisition cost carve-out rates but not credible to support the calculation of the ESRD benchmark rates.

## V. Enhancements to the Part C and D Programs

### A. Reinsurance Exceptions (§ 422.3)

CMS proposes to establish standards for MA plans using reinsurance to limit exposure to medical losses. Specifically, CMS would provide two options: stop loss coverage for costs that exceed \$10,000 per member per year for basic benefits, or first dollar pro rata coverage that does not exceed the cost of purchasing stop loss coverage for medical expenses exceeding \$10,000 per member per year.

**Recommendation:** AHIP applauds CMS for proposing to establish reinsurance standards for the MA program. Establishment of standards helps to provide needed certainty regarding permissible use of reinsurance. At the same time, we have concerns that the proposal does not accommodate other types of risk arrangements that plans can use to reduce costs and offer packages of benefits to meet the needs of Medicare beneficiaries. Therefore, we also suggest that CMS provide additional options that include reinsurance and other types of risk sharing arrangements, including those that allow a minimum percentage of first dollar coverage retained by the plan. This would allow plans further flexibility to find a financial product that would be helpful to deliver benefits to Medicare beneficiaries while still ensuring plans are taking on significant risk.

We also fully support CMS' proposed clarification of its interpretation of Section 1855(b) of the Act to consider parent organizations to be part of MA organizations for purposes of meeting the Act's full risk and reinsurance requirements. Section 1855(b) of the Act requires MA organizations to assume financial risk on a prospective basis for the provision of basic benefits furnished to MA enrollees subject to certain exceptions. In the Proposed Rule, CMS states that it "...wishes to clarify what we consider to be an MA organization for purposes of this statute and is proposing to broaden our interpretation to include parent organizations. The result of that would be to evaluate compliance with section 1855(b) of the Act and proposed §422.3 at the parent organization level, such that risk

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<sup>23</sup> See, for example: FFS data, trends, and ratebook supporting data for the MA and Part D Advance Notice and Final Rate Announcement (available online at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents>); and the data files supplementing the comment period for the Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2020 (available online at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-P>).

sharing or allocations of losses and costs among wholly-owned subsidiaries would not be evaluated.”<sup>24</sup>

We believe that CMS’ clarification to include parent organizations of wholly owned MA organizations is consistent with the intent of the Act. As one of its financial requirements for MA organizations, Congress implemented Section 1855(b) to ensure MA organizations were able to cover the costs associated with providing beneficiaries with the services they were entitled to receive. Reinsurance and analog guarantees between MA organizations’ and their parent organization are long standing routine arrangements that meet a core policy goal of the Medicare program, to safeguard payment of claims and by extension, the beneficiaries who generated those claims. Parent organizations of wholly owned MA organizations are not true third-party organizations for which there is no nexus with CMS. Indeed, an MA organization with a 100% reinsurance arrangement with a parent would still meet all coverage, payment, and program integrity rules and remains the responsible party to CMS while also allowing for efficiencies in administration of the benefit program and more solid protection against financial exposure from unexpected changes in health care costs. Accordingly, we support CMS’ proposal to clarify its interpretation by considering the parent organization to be part of an MA organization for purposes of Section 1855(b) of the Act.

#### *B. Out-of-Network Telehealth at Plan Option*

CMS solicits comments on whether to extend current regulations, which allow MA plans to treat additional telehealth benefits (ATBs) provided by contracted providers as basic benefits, to also include non-contracted providers.

**Recommendation:** We support CMS permitting (but not requiring) all MA plan types, including PPOs, to offer ATBs through non-contracted providers and treat them as basic benefits under MA. In the wake of COVID-19, CMS expanded permissible coverage for telehealth under the MA program to ensure Medicare beneficiaries can receive telehealth services at home to avoid placing themselves at greater risk of the virus. We applaud CMS for providing this coverage flexibility and believe that expansion of the current telehealth policy to permit MA plans to cover telehealth services provided by out-of-network providers as basic benefits is also appropriate.

#### *E. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.164, 422.166, 422.252, 423.182, 423.184, and 423.186)*

CMS proposes changes to the MA and Part D Star Ratings program, beginning with the CY 2021 measurement period and the 2023 Star Ratings. We have the following specific comments and recommendations on the proposed changes and on current program requirements that CMS has not specifically proposed to change in the Proposed Rule.

- **Cut point methodology.** For 2023 Star Ratings, CMS proposes to revise the cut point methodology for non-CAHPS measures by direct removal of observations considered Tukey

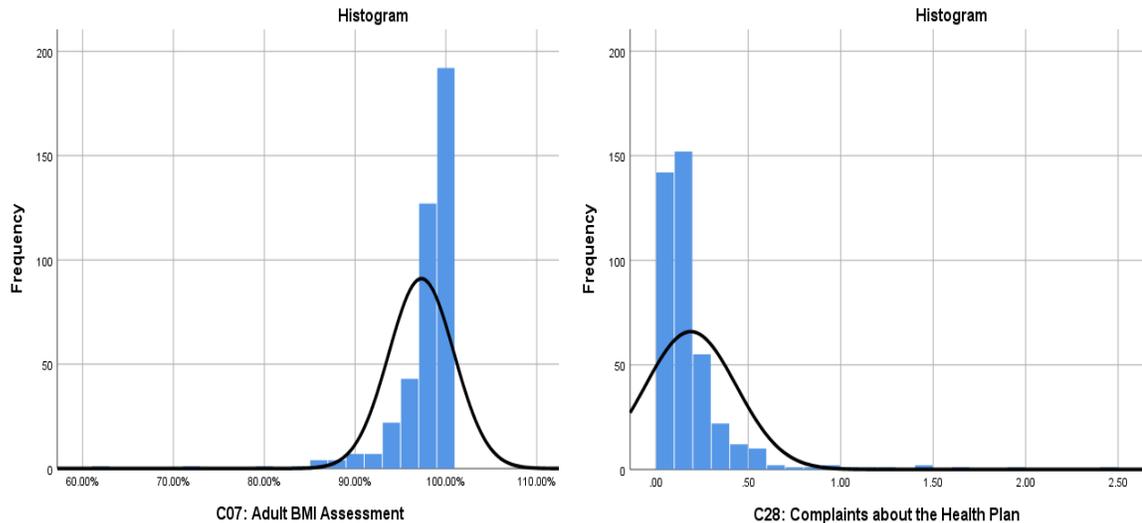
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<sup>24</sup> 85 Fed. Reg. at 9041.

outliers.<sup>25</sup> CMS explains that its proposal would increase the stability and predictability of the non-CAHPS measure cut points. In its regulatory impact analysis, CMS further indicates that the proposed change to the cut point methodology would reduce Star Ratings for contracts and thereby reduce MA payments by \$808.9 million for 2024, increasing to \$1,449.2 million by 2030.<sup>26</sup>

There are many different statistical methodologies available to identify and address outlier observations. However, CMS has not explained why the agency specifically proposed the Tukey outlier methodology as compared to any of the other available methodologies. CMS has also not adequately defined what an ‘outlier’ is in the context of performance measurement for Star Ratings, including at what point in the measurement process outliers would be identified and excluded. Given the potential methodological flaws of this methodology – described in greater detail below – we believe the proposal is premature at this time and would require further analysis by statistical and measurement experts representing a range of stakeholders before being appropriately considered.

We have concerns that application of the Tukey outlier methodology in the Star Ratings program would be flawed. The Tukey outlier methodology is based on the assumption of a normal distribution of the underlying data<sup>27</sup>; however, many measures in the Star Ratings program have distributions with non-normal distributions, for example because they are significantly skewed in one direction. To illustrate this issue, in the charts below we show histograms of the Adult BMI Assessment and Complaints about the Health Plan scores by contract using 2020 Star Ratings data. The actual distributions of scores are represented in the blue bars, and standard normal distributions are imposed in black for comparison.



<sup>25</sup> Under the Tukey outlier methodology, observations that fall outside a range – in this case, 3 times the interquartile range – would be deemed outliers and removed from the values used to calculate the measure level cut points.

<sup>26</sup> 85 Fed. Reg. at 9044.

<sup>27</sup> Hubert, M., Vandervieren, E. An adjusted boxplot for skewed distributions. *Computational statistics & data analysis* 52(12): 5186-5201. August 2008.

These charts demonstrate the distribution of scores on the Adult BMI Assessment measure (a long-standing process measure from HEDIS) as well as the Complaints about the Health Plan measure (a CMS administrative measure based on the Complaints Tracking Module) are both highly skewed and therefore not normally distributed. Several other measures across data sources included in the Star Ratings program have non-normal distributions, making the Tukey outlier methodology inappropriate for those measures.

Additionally, the attached analysis by Wakely found that CMS may have significantly underestimated the adverse impact of this proposal on Star Ratings for plans.<sup>28</sup> Specifically, Wakely estimates that applying the Tukey outlier methodology in the calculation of cut points for 2023 Star Ratings would reduce MA spending by \$1.4 billion. This would cut MA plan payments in just the first year by nearly 2 times more than CMS estimated. Nearly one-quarter of MA contracts would have their performance reduced by 0.5 Stars as a result of the methodology change.

**Recommendation:** AHIP opposes CMS’ proposal. While we appreciate CMS’ goal of increasing cut point stability and predictability, we continue to urge the agency to reinstate the policy that will best achieve those objectives: predetermined cut points in advance of the measurement period.

We believe the elimination of pre-determined thresholds has impeded CMS’ goal of promoting continued quality improvement. Another recent analysis by Wakely (see attached) found significant year-over-year volatility in average Star Ratings for Patient Experience/Complaints and Access measures, despite consistent trends in plan performance over time.<sup>29</sup> Wakely concluded that year-over-year changes in the measure cut points drive this volatility and result in a “disconnect between contract performance and contract scores, or Star Ratings.” To address this disconnect, Wakely suggests that “further study of the observed volatility and lack of correlation between performance and measure-level Star Ratings (based on current clustering methodology) is merited.”

The retrospective clustering methodology CMS uses to establish measure cut points has also undermined the ability of plans and their providers to set markers for performance activities that are consistent with CMS’ expectations. Moreover, as plans have transitioned to value-based arrangements with providers, setting goals is essential to help both parties assess the effectiveness of their efforts to improve quality of care and reduce costs while maintaining high performance and rating levels. MedPAC also supports prospectively set performance targets and has noted that retrospectively determined cut points make it “so plans cannot know in advance what outcomes they need to achieve, making it difficult for providers and plans to manage their quality improvement efforts.”<sup>30</sup>

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<sup>28</sup> Wakely Consulting Group. Proposed rule changes to the Medicare Star Rating program: Analyzing the impact of proposed changes on Medicare Advantage spending. March 2020.

<sup>29</sup> Wakely Consulting Group. Star Rating variability of patient experience and access measures: Analyzing the impact of variable Star Rating cut points and measure level results. March 2020.

<sup>30</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2019.

Set cut points in advance of the measurement period would also help to simplify the Star Ratings program and reduce burdens on providers contracting with multiple plans, who otherwise may face varying and conflicting quality performance metrics on the same quality measures. Predetermined cut points would thus promote a key Administration goal of reducing unnecessary regulatory burdens.

Further, we are concerned that CMS' proposed change to the cut point methodology, by reducing scores, would also adversely impact MA beneficiaries. MA plans with a Star Rating of at least 4 stars receive increased funding as an incentive to achieve high performance. Plans use these funds to provide additional benefits and reduce beneficiary cost-sharing. Changes to the Star Ratings program should support, not take away, these vital benefits.

Finally, we ask that CMS provide more details on its methodology so that plans can run similar simulations to better understand the impact of the proposed change to the cut points and plan ratings. For example, CMS does not clearly state: whether the impacts of mean resampling and guardrails, as codified in the 2020 Final Rule, were included in its impact analysis; if the analysis deviated at all from the published clustering methodology, what enrollment and revenue assumptions were used; and why CMS chose to model the impact on 2018 Star Ratings without taking into account other changes to the Star Ratings methodology finalized for 2021 and 2022 Star Ratings. For the reasons stated above, we oppose CMS' proposed change to the cut point methodology.

- **Weight increase of patient experience/complaints and access measures.** CMS proposes to increase the weight of patient experience/complaints and access measures from 2 to 4 for 2023 Star Ratings. This would result in the patient experience/complaints and access measures representing 52% of the overall Star Rating in 2023, an increase from 31% in the 2020 overall Star Rating. CMS assumes that with its proposal more contracts would experience increases in Star Ratings rather than decreases. Specifically, CMS indicates that the proposed change to the weights for these measures would result in an increase in plan payments of \$391.4 million for 2024.

We have serious concerns with this proposal.

- An analysis by Wakely found that CMS may have overestimated the impact on Star Ratings for plans.<sup>31</sup> Specifically, Wakely, using 2020 Star Rating performance data (more recent than the 2018 data used by CMS), estimated that increasing the weights of patient experience/complaints and access measures in the 2023 Star Ratings would only increase MA plan payments by \$83 million – nearly 5 times less than what CMS estimated. While this change would increase the overall Star Rating for some MA contracts, more MA enrollees are in plans that would be negatively impacted when the concurrent Tukey outlier proposed change is taken into account.
- As noted above, Wakely also found that despite relatively consistent trends in plan performance over time, volatility in the cut points for these measures has created

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<sup>31</sup> Wakely Consulting Group. Proposed rule changes to the Medicare Star Rating program: Analyzing the impact of proposed changes on Medicare Advantage spending. March 2020.

volatility and inconsistent trends in contract Star Ratings.<sup>32</sup> For example, average contract performance on the 2020 patient experience/complaints measures using the 2020 cut points resulted in an average Star Rating of 3.68, but this same level of performance would have resulted in an average Star Rating of 4.53 using the 2016 cut points. Wakely concludes that, “increasing the weights for these measures has the potential to erode the stability of the Star Ratings program – by basing the majority of the Star Rating score on measures that have historically shown significant Star Rating volatility despite relatively stable performance in measure level data.”

- Weighting patient experience measures at 4 fails to account for the fact that the measures are based on a limited sample of beneficiaries and their experiences. Measures based solely on surveys and limited sampling may yield inaccurate, unreliable, or biased data. Extraordinary events, including the COVID-19 public health emergency, can also have significant impacts on patient experience/complaints and access.
- Increasing the weight of survey or administrative measures to 4 does not align with CMS’ existing framework for measure categories, definitions and weights or its guiding principles for the program. CMS’ 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. The existing measures framework also calls for outcome and intermediate outcome measures to be weighted at 3, a weight higher than other types of Stars measures (except for the improvement measures). We continue to support these guiding principles and believe it is critical that CMS use them as the framework for assessing weighting of measures for the program.
- The proposal also runs counter to the quality measurement principles of MedPAC, which establish the importance of outcome measures; MedPAC believes administrative measures should not be included at all in MA performance measurement, let alone be weighted the highest, as MA plans “should be held accountable for their insurance functions through compliance standards, not through” performance measurement.

**Recommendation:** We oppose increasing the weight of measures that are based solely on survey or administrative data to 4 and request that CMS not finalize the proposal. We also urge CMS to first provide more details on its methodology through formal notice and comment rulemaking. This will allow plans to run similar simulations to better understand the impact of the proposed change to the weighting for these measures and plan ratings, and thereby offer a more meaningful comment opportunity.

- **Part C Rheumatoid Arthritis Management measure.** CMS proposes to remove the Rheumatoid Arthritis Management measure from 2023 Star Ratings. CMS notes that NCQA is retiring this measure due to multiple reasons that would impact plan performance,

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<sup>32</sup> Wakely Consulting Group. Star Rating variability of patient experience and access measures: Analyzing the impact of variable Star Rating cut points and measure level results. March 2020.

including concerns that members may receive anti-rheumatic drug therapy through Patient Assistance Programs, which do not generate claims.

**Recommendation:** We agree and support CMS' proposal.

- **Health Outcomes Survey (HOS) measures.** CMS proposes to make substantive changes to two HOS measures (Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures), including modifying the case-mix adjustment and increasing the minimum required denominator from 30 to 100 for 2023 Star Ratings. CMS indicates that increasing the sample size would help to improve the reliability for HOS measures.

While increasing the sample size may be helpful in improving reliability of HOS measures relative to the current approach, we would continue to have significant concerns with the reliability even with such change. As we indicated in our comments in response to the Advance Notice for CY 2021, there is significant variability in plan performance year to year on HOS measures and research has identified reliability issues with patient reported outcome measures.<sup>33</sup> We are also concerned that performance on these measures is heavily influenced by factors beyond the care received by the patient, and there is limited evidence of the measures' responsiveness to health care interventions. We are also concerned that extraordinary events, including the COVID-19 public health emergency, could impact plan performance on HOS measures.

**Recommendation:** Given the concerns about HOS measures noted above, we recommend that CMS focus on developing standards through notice and comment rulemaking for reliability of all Star Ratings measures, including HOS measures. As part of that effort, CMS should analyze and share its findings on the reliability of HOS measures and plan performance results.

Furthermore, the proposed changes to the two HOS measures are substantive and therefore CMS should clarify in the final rule that they would be moved to the display page for 2023 and 2024 Star Ratings. In order for plans to also better assess reliability, we ask that CMS provide plans with access to inter-unit reliability data for the HOS measures (Improving or Maintaining Physical Health and Improving or Maintaining Mental Health measures), under the current and proposed new case mix methodology.

- **Part D Statin Use in Persons with Diabetes Measure.** The Part D Statin Use in Persons with Diabetes (SUPD) measure has a weight of 1 for 2020 Star Ratings. CMS decided to classify the measure as an intermediate outcome measure with a weight of 3 starting with 2021 Star Ratings in the 2019 MA and Part D final rule published in April 2018.<sup>34</sup> CMS is now proposing to reclassify the Part D SUPD measure as a process measure with a weight of 1 for 2023 Star Ratings because it "no longer believe[s] that is the appropriate

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<sup>33</sup> [https://www.rand.org/pubs/research\\_reports/RR1844.html](https://www.rand.org/pubs/research_reports/RR1844.html)

<sup>34</sup> 83 Fed. Reg. 16440 (April 16, 2018).

classification.”<sup>35</sup> 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.<sup>36</sup>

**Recommendation:** We support CMS’ proposed change to the weight and classification of this measure. However, we continue to recommend that the measure remain a process measure with a weight of 1, as it has been through 2020 Star Ratings (including for the improvement measure calculation). Under the proposal as written, the weighting would jump to 3 for 2021 and 2022 Star Ratings and then revert back again to a weighting of 1 for 2023 Star Ratings. This instability is not good for the Star Ratings program. While we commend CMS for adhering to the timing of changes as reflected in regulations, we believe the unique nature of this situation makes it appropriate for CMS to treat it as a technical correction that takes effect for 2021 Star Ratings.

- **Part C Transitions of Care Measure.** CMS proposes to add this measure to the Star Ratings in 2023 covering the 2021 measurement period. While we understand the importance of measuring transitions of care, we have raised several concerns and questions relating to data challenges and other issues affecting this display measure in our comments in response to the Advance Notice for CY 2021. 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.
  - Communications from other types of providers that may support a beneficiary during a care transition should be counted. 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 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. These challenges may be exacerbated due to the impact of COVID-19 on health care providers and systems.
  - CMS does not provide information on how the changes to the Transitions of Care measure will impact the related Medication Reconciliation Post-Discharge Star Ratings measure.
  - NCQA’s requirement that all four elements be completed may not appropriately account for variation of performance on the different elements.
  - 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.

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<sup>35</sup> 85 Fed. Reg. at 9046.

<sup>36</sup> <https://www.pqaalliance.org/measures-overview#supd>

**Recommendation:** We do not support the addition of this measure to the 2023 Star Ratings and ask that CMS keep this measure on the display page for 2023 Star Ratings (and possibly beyond) so that CMS can address the concerns we have raised, and organizations have 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.

- **Extreme and Uncontrollable Circumstances Policy.** In the Proposed Rule, CMS solicits feedback on its disaster relief policy, including for contracts impacted across multiple years.

We continue to strongly believe that CMS should expand eligibility criteria under the disaster relief policy to cover more extreme and uncontrollable events (e.g., COVID-19 and other public health emergencies) that impact plan performance. Moreover, the policy should also be applied to all years affected by the event.

For example, COVID-19 has affected the ability of MA and Part D plans to collect accurate data, and the ability of plans and their contracted providers to meet certain metrics for the 2019 and 2020 performance periods (2021 and 2022 Star Ratings). Travel bans, quarantines, and other related measures are limiting normal patient engagement activities and creating significant challenges in collecting certain types of data from providers, such as medical records. In addition, as hospitals, physicians, other providers and patients prioritize emergency functions over non-essential clinical care and administrative functions, enrollees are delaying or have difficulty accessing normally available and recommended preventive and other health care services. Moreover, public health recommendations on social distancing and a heightened level of uncertainty may lead to lack of physical activity, isolation, loneliness, and anxiety and thereby impact various quality and patient experience survey measures for all beneficiaries.

We also note that CMS has provided significant quality reporting relief to providers in numerous FFS programs because of COVID-19.<sup>37</sup> CMS justified this decision based on the recognition, "that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period."

On March 31, CMS released an interim final rule with comment period (IFC) that includes modifications to the 2021 and 2022 MA and Part D Star Ratings.<sup>38</sup> In the IFC, CMS indicates that the changes the agency will make to the calculation of the 2021 and 2022 Star Ratings address the anticipated disruption to data collection and measure scores resulting from the COVID-19 pandemic. We support changes (and further adjustments if necessary) that ensure

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<sup>37</sup> CMS Announces Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19 March 22, 2020, available online at <https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting>

<sup>38</sup> 85 Fed. Reg. 19230, <https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf>

plan ratings for 2021 and 2022 are not adversely impacted due to the COVID-19 pandemic. We will also provide these and other recommendations in response to the IFC.

**Recommendation:** We recommend that CMS make changes (and future adjustments if necessary) included in the IFC to ensure that plan ratings for 2021 and 2022 are not negatively impacted due to COVID-19. Given the current exceptional circumstances, we also ask that CMS not apply the low performing icon to any plan for 2021 Star Ratings. In addition, CMS should consider a process allowing plans to demonstrate that absent COVID-19 they would have been able to receive higher Star Ratings. The agency should consider making adjustments to those impacted plans' ratings without adversely impacting other plans' ratings.

We also urge CMS to expand the eligibility criteria in its disaster relief policy 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.

We also ask CMS to consider expanding its policy that covers contracts impacted by two different extreme and uncontrollable events in consecutive years to also include contracts impacted by a single disaster spanning multiple years. This would allow CMS' disaster relief policy to account for disasters, or other uncontrollable circumstances, that have longer lasting impacts or occur at the end of a coverage year.

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 urge that no plan be adversely impacted under this policy. To eliminate adverse impacts on multi-year affected contracts, CMS should apply a longer look back period under its policy. CMS' policy should also ensure that non-affected contracts are not disadvantaged due to disaster-relief related Star Ratings adjustments.

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.

*F. Permitting a Second, "Preferred", Specialty Tier in Part D (§§ 423.104, 423.560, and 423.578)*

Currently, Part D sponsors can include a specialty tier for high-cost drugs in their plan designs. The Proposed Rule would allow sponsors to offer a second specialty tier, subject to certain conditions. The higher cost-sharing specialty tier would be subject to maximum allowable cost-sharing of between 25% and 33% (depending on the level of deductible), consistent with current rules. The second specialty tier would be a "preferred" tier that offers lower cost-sharing. Drugs on the higher-cost specialty tier would be subject to tiering exception requests to the preferred tier. However, plans could exempt drugs on either specialty tier from tiering exceptions to non-specialty tiers. In addition,

Part D sponsors would have flexibility in deciding which of the specialty tiers to place eligible high-cost drugs. The proposal would not specify any minimum required difference between the cost-sharing levels of the higher cost and preferred tiers. Finally, the Proposed Rule codifies current methodologies for establishing specialty tier thresholds and eligibility of particular drugs to be placed on the tiers, with some modifications that include basing determinations on ingredient cost rather than negotiated price and making adjustments in increments of not less than 10% rounded down to the nearest \$10 based on an annual analysis of prescription drug event data.

**Recommendation:** AHIP has long advocated for permitting a preferred specialty tier in Part D. Accordingly, we strongly support CMS' proposal. We agree with CMS that a second specialty tier will improve the ability of Part D sponsors to negotiate larger discounts from drug manufacturers in exchange for preferred formulary placement and encourage Part D enrollees to use the most cost-effective drugs. We appreciate the Administration's repeated recognition of the importance of expanding private-sector negotiating tools, competition and choice, which leads to lower patient cost-sharing, reduced premiums, savings for plan customers like employers and states, and lower costs for taxpayers. The proposal is also consistent with a prior recommendation from MedPAC, which further noted the potential for two specialty tiers to encourage competition among drug manufacturers.<sup>39</sup>

In addition to supporting the overall policy, we want to acknowledge our support for various components of the proposal that offer flexibility in benefit design. Such provisions, individually and in combination, are important to achieving the goals of encouraging negotiation and cost-effective drugs, enhancing competition, and reducing costs. In particular:

- **Giving sponsors discretion in placement of drugs between specialty tiers.** We support CMS' proposal to give plans flexibility to determine which drugs will be placed on each specialty tier. This will enable plans to structure the benefit in a way that encourages enrollees to use the most cost-effective drugs.

CMS requests input on an alternative approach that would limit the preferred tier to generics and biosimilars. We oppose such an approach. If implemented, the restriction would limit the ability of plans to negotiate the highest potential discounts from drug manufacturers. Moreover, high-priced generics are increasingly commonplace (see e.g., the table below showing average spending per claim for the top 10 most costly multisource generics in Part D in 2018). Moreover, generics and biosimilars are not always the lowest cost therapeutic alternative for a given condition. We also believe tiering based on drug cost, rather than exclusively based on labels like brand or generic, is a more meaningful approach for beneficiaries. Accordingly, we urge CMS to move forward with its proposed approach and not impose limits on tiering composition that can raise costs in the Part D program.

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<sup>39</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2016.

Generic Name	Number of Manufacturers	Average Spending Per Claim
Bexarotene	4	\$19,047.87
Flucytosine	5	\$8,703.86
Phenoxybenzamine HCl	3	\$7,883.81
Abiraterone Acetate	5	\$7,346.42
Imatinib Mesylate	11	\$5,581.19
Tetrabenazine	8	\$4,451.16
Metformin HCl	5	\$4,021.48
Azacitidine	7	\$3,968.56
Dihydroergotamine Mesylate	3	\$3,076.10
Tobramycin In 0.225% Sod Chlor	5	\$2,719.61

Source: Medicare Part D Drug Spending Dashboard & Data.

- Imposing a maximum cost-sharing based on the level of deductible.** We support CMS’ proposal to allow higher cost-sharing on the specialty tier for plans with reduced or no deductible, consistent with current rules. The flexibility encourages competition and choice in benefit design, including plans with different deductible levels, thereby helping beneficiaries have access to options that best meet their needs. Moreover, even with the increased cost-sharing percentage, enrollees covered by drugs on the specialty tier can still pay considerably less than they would if the drugs were placed on a non-specialty tier with higher cost-sharing.

Conversely, AHIP would oppose a change in rules that would impose a maximum 25% cost-sharing on the specialty tier regardless of whether there is a deductible. The agency solicits comments on such an approach, indicating it is unclear why the specialty tier should be differentiated from other tiers on the basis of the deductible. However, since its creation the specialty tier has been differentiated from other tiers in various ways. They include limiting the specialty tier to certain drugs based on cost; restricting the cost-sharing amount to the amount permitted under the defined standard benefit – either 25% with a standard deductible, or an actuarially equivalent amount with a reduced or no deductible; and exempting the specialty tier from tiering exceptions. Taken together, these provisions are designed to encourage lower cost-sharing for high cost drugs while minimizing cost-sharing and premium impacts throughout the benefit. If CMS eliminated the ability of plans to charge actuarially equivalent amounts for high cost drugs when deductibles are reduced, it would mean plans with reduced deductibles may need to raise costs for drugs on other tiers and/or increase premiums to achieve actuarial equivalence. Changing the cost-sharing rule therefore would be inconsistent with the steps the Administration has taken to enable Part D sponsors to increase choice and reduce costs and premiums for all seniors.

- No required difference in cost-sharing between specialty tiers.** We support CMS’ proposal to require no minimum differential between the two specialty tiers. As CMS notes, this approach encourages flexibility and recognizes the difficulty for CMS in anticipating

potential design variations. We also agree with CMS that “it would be unlikely that Part D sponsors would take the trouble to create two different tiers and then establish an inconsequential differential.”<sup>40</sup> We commend CMS’ practical approach of not creating an unnecessary regulatory restriction up front, while potentially reexamining the policy in the future based on actual experience.

- **Exemption from tiering exception to non-specialty tiers.** We support CMS’ proposal to allow plans to exempt drugs on both specialty tiers from tiering exceptions to a non-specialty tier, consistent with the exemption that currently applies to the specialty tier. As CMS explains, the requirement that Part D sponsors offer a plan that is actuarially equivalent to the Defined Standard benefit might force Part D sponsors to increase premiums and cost-sharing for non-specialty drugs if Part D enrollees are able to obtain drugs on specialty tiers at any non-specialty tier cost-sharing that may be available. We agree that it is important for CMS to avoid such increased costs by continuing a policy that has been in place since the start of the Part D program. As CMS suggests, exempting specialty tier drugs from tiering exceptions to non-specialty tiers also improves Part D sponsors’ ability to negotiate deeper discounts with manufacturers. We see no basis to modify the policy at a time when CMS is permitting a second specialty tier that could give enrollees access to even lower cost-sharing than the original specialty tier.

We also appreciate CMS’ recognition in the preamble that permitting higher cost-sharing in the non-preferred tier compared to current rules can allow plans to negotiate even higher discounts for the preferred specialty tier, and could lead to lower premiums. We recommend that CMS continue to analyze this issue for future rulemaking.

#### *G. Beneficiary Real Time Benefit Tool (RTBT) (§ 423.128)*

CMS proposes to require that Part D plans develop a real time benefit tool (RTBT) that is patient-specific and includes formulary and benefit information by 2022. The proposal would require that the RTBT include accurate, timely, and clinically appropriate patient-specific real-time formulary and benefit information (including enrollee cost-sharing information, clinically appropriate formulary alternatives, and the formulary status of each drug presented including any utilization management requirements). To make the tool understandable to the average patient who typically does not have a clinical background, and to account for complexities in assessing alternatives for some drugs or drug classes/categories (such as drugs with significant side effects), the proposal would allow plans to use P&T committees to omit drugs in clinically appropriate circumstances from the beneficiary RTBT, even though those drugs may be required in the prescriber RTBT (which plans must implement by January 1, 2021<sup>41</sup>). The proposal would allow plans to add the tool to an existing beneficiary portal, create a new patient portal for this purpose, or enable beneficiaries to access the RTBT through a computer or smart phone application. Plans would also be required to make this information available to enrollees via their customer service call center. Plans would be encouraged but not required to include pharmacy-specific cost-sharing information and negotiated prices in the

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<sup>40</sup> 85 Fed. Reg. at 9055.

<sup>41</sup> Modernizing Part D and Medicare Advantage To Lower Drug Prices and Reduce Out-of-Pocket Expenses, 84 Fed. Reg. 23834, 23847 et seq. (May 23, 2019).

beneficiary RTBTs. Lastly, the proposal allows plans to offer rewards and incentives to enrollees who use the tool subject to certain conditions.

**Recommendation:** We support the proposal, including elements that would provide flexibility on information plans are required to offer through the tool, such as exclusion of certain drugs and not requiring disclosure of negotiated prices. We also support CMS providing flexibility in how plans offer the RTBT. In addition, we support CMS' proposal to allow plans to encourage use of the tool through rewards and incentives.

However, we recommend that CMS make the 2022 effective date voluntary, with a mandatory effective date of 2023. The prescriber tool has not yet been introduced and prescribers will need time to become fully acquainted before beneficiaries can discuss these tools with them. Furthermore, plans currently developing prescriber tools will need to consider making appropriate changes to the existing tool for beneficiary use. This process will take time and resources, particularly if plans limit information based on clinically appropriate determinations by their P&T committees and implement additional beneficiary focused modifications (e.g., use of plain language). Additionally, CMS should provide as much flexibility as possible for plans to determine how to display formulary alternatives in a manner that is most practical and useful for beneficiaries.

We also note that plans are currently under enormous pressures relating to technology projects, including the need to implement and do likely follow-up work relating to the prescriber RTBT; activities required to implement the recently-released final interoperability rule; and the broad range of issues affecting plans in connection with the COVID-19 public health emergency. A voluntary 2022 effective date for those plans able to meet it, with a longer period for others, is needed to provide plans with sufficient time to develop, test and refine these tools and to educate their network providers and enrollees about their availability and use.

*I. Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440)*

CMS proposes to allow incurred claims in the MLR numerator to include amounts paid to non-providers for covered services, which would also cover the expanded supplemental benefits now available for MA plans.

**Recommendation:** AHIP strongly supports this MLR proposal. This approach would provide clarity about how plans should report these amounts and encourages MA plans to offer supplemental benefits to better address social barriers to care and other needs of MA enrollees.

*J. Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration and Part D Coverage Determination and Redetermination Requests (§§ 422.568, 422.570, 422.582, 422.584, 422.590, 422.592, 422.631, 422.633, 423.568, 423.570, 423.582, 423.584, and 423.600)*

CMS proposes to establish processes for the withdrawal or dismissal of: Part C organization determination and reconsideration requests, Part D coverage determination and redetermination requests, and Part C and Part D independent review entity (IRE) reconsiderations.

**Recommendation:** AHIP recommends that CMS ensure that the final regulatory requirements are not more restrictive than current CMS guidance. For example, CMS’ proposal indicates that only a timely written request can be used to withdraw a request whereas current CMS guidance indicates that verbal notifications are also acceptable.<sup>42</sup> CMS should continue to permit verbal withdrawal requests. For clarity, we also recommend that CMS structure the Part C and Part D regulatory text the same way where possible. For example, in §422.584 (Expediting certain reconsiderations) CMS repeats the rules from a different section while §423.584 (Expediting certain redeterminations) cross refers to them. These minor distinctions can generate questions and confusion and should be eliminated when possible.

## **VI. Codifying Existing Part C and D Program Policy**

### *A. Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services (§§ 422.100 and 422.101)*

Unlike the traditional Medicare program, MA plans are required under current regulations to implement an annual MOOP limit for all enrollees. CMS sets two MOOP limits each year: 1) a “mandatory” MOOP representing the maximum limit a plan can impose, estimated as the out-of-pocket costs incurred at the 95<sup>th</sup> percentile of projected traditional Medicare beneficiary spending; and 2) a “voluntary” MOOP, estimated as the out-of-pocket costs incurred at the 85<sup>th</sup> percentile of projected traditional Medicare beneficiary spending. In 2020, the mandatory MOOP limit is \$6,700 and the voluntary MOOP limit is \$3,400. Plans offered at the voluntary MOOP limit or below are provided additional flexibility in benefit design.

Beginning in 2022, CMS is proposing three changes to the regulations governing how the MOOP limit for MA plans is determined: 1) establishing explicit authority for the agency to set up to three MOOP limits, 2) codifying the methodology for setting the MOOP limits, and 3) adjusting the methodology for setting the MOOP limits to take into account the removal of restrictions on beneficiaries with ESRD being allowed to enroll in MA plans beginning in 2021. Through these proposals, CMS would create a new third MOOP limit – referred to in the Proposed Rule as the “intermediate” MOOP limit – set in-between the existing mandatory MOOP limit and the “lower” (renamed from “voluntary”) MOOP limit. In addition, CMS would phase-in additional costs incurred by beneficiaries with ESRD into the MOOP limit calculation over time.

AHIP supports the new intermediate MOOP. In addition, we strongly support CMS taking the “ESRD cost differential” – or difference between projected traditional Medicare beneficiary out-of-pocket spending including vs. excluding beneficiaries with ESRD – into account in setting the MOOP limits. However, we have concerns with the complexity and potential length of the phase-in schedule proposed by CMS. We also note that while necessary, these changes to the rules around plan benefit design as proposed may increase costs for all beneficiaries and will not fully address longstanding concerns regarding the adequacy of MA payment rates for beneficiaries with ESRD.

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<sup>42</sup> <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf>

In the CY 2021 Part C Benefits Review and Evaluation (Part C bidding instructions), CMS proposed to partially incorporate traditional 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 the Proposed Rule, CMS proposes to increase that percentage by 20 percentage points each year, with guardrails to limit any year-over-year increases beyond a certain amount, until the ESRD cost differential is fully reflected in 2024 or later. However, CMS projects that 50% of the beneficiaries with ESRD anticipated to enroll in MA by 2026 will enroll in 2021.

While we have questions about whether CMS' projection understates actual enrollment, in response to the 2021 Part C bidding instructions we recommended that CMS at a minimum reflect its full estimate and therefore incorporate 50% of the costs of ESRD enrollees in the MOOP limit calculation (rather than 40%) for 2021. In addition, we are concerned that CMS' proposal to mitigate significant year-over-year increases in the MOOP limits by phasing in the ESRD cost differential is overly complex and may be difficult for plans to project for business planning purposes.

**Recommendation:** To increase transparency as well as predictability, we recommend that CMS simplify the methodology for incorporating the remainder of the ESRD cost differential over time. For example, CMS could phase-in the remainder of ESRD cost differential at a fixed rate of 25% percentage points annually through 2023 as follows: 50% in 2021, 75% in 2022, and 100% in 2023.

CMS also seeks comment on whether to codify a rule requiring the agency to issue sub-regulatory guidance applying the MOOP limit methodology each year.

**Recommendation:** We support CMS in codifying a rule that requires the agency to issue sub-regulatory guidance applying this methodology each year. The annual deadline for issuing this guidance should align with the schedule for issuing the Advance Notice of Methodological Changes (i.e., no later than 60 days prior to the first Monday in April with a minimum 30-day comment period).

*B. Service Category Cost-sharing Limits for Medicare Parts A and B Services and Per Member Per Month Actuarial Equivalence Cost-sharing (§§ 422.100 and 422.113)*

In addition to an annual MOOP limit, CMS imposes limits on plan cost-sharing for individual services. These limits are intended to ensure cost-sharing is the same or lower (on an actuarially equivalent basis) to the traditional Medicare program as well as to protect beneficiaries against potential discriminatory benefit designs.

In the Proposed Rule, CMS has proposed to codify its current policies and methodology for interpreting and applying limits on MA cost-sharing for basic benefits, including flexibility for plans applying a MOOP below the maximum limit, with some modifications. These modifications include how the service-specific limits will be set for plans implementing the new intermediate MOOP limit, how the limits apply to copayments, and additional requirements regarding how comparisons between MA plan and traditional Medicare cost-sharing are conducted to ensure the benefits are at least equivalent on an actuarial basis.

Consistent with the MOOP limits, in the Proposed Rule and in the CY 2021 Part C bidding instructions CMS is proposing to incorporate 40% of the ESRD cost differential into the calculation of the service-specific PMPM cost-sharing limit for inpatient hospital acute and psychiatric services for 2021.<sup>43</sup> This percentage would increase to 60% in 2022, 80% in 2023, and 100% in 2024. In our response to the Part C bidding instructions, we recommended that CMS incorporate 50% of the ESRD cost differential in 2021 to align with OACT's enrollment projections.

**Recommendation:** We recommend that CMS use the same schedule for incorporating the ESRD cost differential in the inpatient hospital acute and psychiatric services as the MOOP limits – we offer the example above of 50% in 2021, 75% in 2022, and 100% in 2023. In addition, we recommend CMS release the methodology used for setting these cost-sharing limits in sub-regulatory guidance each year consistent with guidance on the MOOP limit methodology.

*C. Plan Crosswalks for Medicare Advantage (MA) Plans and Cost Plans (§§ 417.496 and 422.530)*

CMS proposes to codify the current process and conditions for plan crosswalks. Additionally, CMS proposes to codify the rules for crosswalk exceptions, including permissible D-SNP to D-SNP crosswalks.

**Recommendation:** In order to minimize administrative and regulatory burdens, we recommend that CMS classify permissible SNP to SNP crosswalks exceptions as permissible plan crosswalks. We also recommend that the SNP organization not be required to provide enrollees transitioned from one SNP to another with an Annual Notice of Change (ANOC) if there are no substantive changes in enrollee premiums, benefits, and cost-sharing as a result of the transition.

*E. Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)*

General

CMS proposes to codify the existing network adequacy standards with several modifications. The agency proposes to reduce the percentage of beneficiaries required within specified time and distance standards in rural areas; provide a 10 percentage point credit towards meeting time and distance standards for certain specialty types when the plan contracts with telehealth providers for those specialties; and provide a 10 percentage point credit toward the percentage of beneficiaries residing within time and distance standards for affected provider and facility types in states with certificate of need (CON) laws or other anti-competitive restrictions.

**Recommendation:** We support CMS's proposed changes that enhance network adequacy flexibility. However, we also request that CMS consider expanding that flexibility in several ways:

- **Telehealth.** The COVID-19 pandemic has reinforced how critical it is from a public policy perspective to encourage the widespread availability of telehealth services. To further

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<sup>43</sup> Note that based on an analysis by OACT, CMS does not estimate that incorporating costs for traditional Medicare beneficiaries with ESRD into the calculations will affect other service-specific cost-sharing limits and therefore does not propose a transition schedule for changing the methodology as it relates to these other services.

encourage its growth, the agency should expand the specialty types eligible for the telehealth network credit to include, at a minimum, allergy and immunology, nephrology, ophthalmology, and primary care. We also believe CMS should consider for future rulemaking a more wide-ranging reassessment of the established time and distance standards given the rapid growth of telehealth technology and the potential for easier access and lower costs.

- **Rural.** While we appreciate the reduction of beneficiaries in rural areas who must be within time and distance standards and we support 85%, we encourage CMS to analyze the impact of a further reduction (for example 80%) in future rulemaking, including whether a lower number would impact MA penetration. Furthermore, we encourage CMS to streamline the network exception request process by considering ways to minimize reporting burdens associated with resubmissions of previously approved requests.

We support these additional flexibilities for CY 2021. For plans to be able to adjust their networks appropriately, CMS should release additional guidance and updated health service delivery (or HSD) tables as soon as possible before bids are due. We also ask that CMS and health plans work together to consider additional flexibilities in standards in states that have CON laws; and modify the exceptions criteria and process in ways that reduce burden, improve consistent reviews, and reflect the changing healthcare landscape.

### Dialysis Services

CMS seeks comment on proposals to enhance current network adequacy requirements around the provision of dialysis services in order to reduce costs, improve quality, and increase beneficiary convenience and quality of life. The outpatient dialysis market is highly concentrated, with two companies currently controlling nearly 75% of dialysis services available to Medicare beneficiaries.<sup>44</sup> Recent research has found that, while overall beneficiary outcomes – as measured by hospital days and mortality – have improved over time, outcomes in independently owned facilities acquired by these two companies were negatively impacted after acquisition.<sup>45</sup> These results are a “cautionary tale” and raise concerns about the role of consolidation in the dialysis industry.<sup>46</sup> Consolidation in the dialysis market has also led to significantly higher prices – for one large dialysis provider, commercial insurers paid an average rate per treatment four times higher than government programs in 2017.<sup>47</sup>

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<sup>44</sup> Analysis of CMS Medicare Dialysis Facility Compare - Listing by Facility data. Last updated on January 22, 2020. Available online at: <https://data.medicare.gov/Dialysis-Facility-Compare/Dialysis-Facility-Compare-Listing-by-Facility/23ew-n7w9>

<sup>45</sup> Erickson, K.F., Zhao, B., Niu, J., et al. Association of hospitalization and mortality among patients initiating dialysis with hemodialysis facility ownership and acquisitions. *JAMA Network Open* 2(5):e193987. May 2019.

<sup>46</sup> Wang, V., Maciejewski, M.L. Patient outcomes and dialysis consolidation—Two big to fail? *JAMA Network Open* 2(5):e193962. May 2019.

<sup>47</sup> Childers, C.P., Dworsky, J.Q., Kominski, G. et al. A Comparison of payments to a for-profit dialysis firm from government and commercial insurers. *JAMA Internal Medicine* 179(8):1136–1138. May 2019.

As Secretary Azar has aptly noted, “88 percent of Americans with ESRD start treatment with center-based dialysis. Just 12 percent start treatment at home with hemodialysis or peritoneal dialysis. This is the complete opposite of the situation in some of our peer nations, including Hong Kong, where more than 80 percent of patients benefit from some form of in-home dialysis. Improving this situation dramatically, as we ought to do, will mean examining the payment incentives in our programs today, while expanding access to new technologies.”<sup>48</sup> Moreover, CMS has acknowledged that home dialysis is often preferred over facility-based dialysis by both patients and providers. The ESRD Treatment Choices payment model is being implemented in traditional Medicare to reverse this trend by overhauling the delivery of kidney care. Expansion of home dialysis and other alternative delivery methods is all the more important during the COVID-19 public health emergency: people with serious illness and/or a compromised immune system are more vulnerable to the spread of coronavirus, and need to have a viable treatment infrastructure that allows them to access life-saving dialysis services while protecting them from exposure to infection.

AHIP appreciates and strongly supports CMS enacting policies in the MA program to enhance network contracting options to promote innovation, increase access, and reduce costs for beneficiaries with ESRD who choose to enroll in MA plans. MA plans are already developing and employing new ways to improve health and outcomes for beneficiaries with ESRD, including the initial expansion of home dialysis to individuals for whom it is clinically appropriate; new value-based care models to incentivize the delivery of higher-quality, evidence-based care; and new home hemodialysis devices being piloted in clinical trials to bring them to market as early as possible. We believe advancements in dialysis technology and the expansion of options for providing dialysis treatment at home are near a tipping point, and that the modifications to network adequacy requirements are greatly needed for MA plans to deliver on the goals articulated in the Administration’s Advancing American Kidney Health Initiative.

**Recommendation:** We strongly support CMS implementing two of the changes to MA plan network adequacy requirements for dialysis services that the agency identified: 1) removing outpatient dialysis from the list of facility types for which MA plans need to meet time and distance standards, and 2) allowing plans to attest to providing medically necessary dialysis services in its contract application instead of requiring each MA plan to meet time and distance standards for providers of these services. These changes would be consistent with how CMS monitors and ensures MA beneficiary access to durable medical equipment, home health care, and transplant services. By allowing MA plans to attest they are providing medically necessary dialysis services in their contract applications, CMS will ensure patient protection while also giving plans the flexibility they need to expand the delivery of innovative solutions to beneficiaries with ESRD requiring dialysis treatment. This is especially critical at a time when enrollment of beneficiaries with ESRD is expected to rapidly increase and is reinforced by the need to identify alternatives to facility-based care as a result of the COVID-19 crisis.

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<sup>48</sup> Alex M. Azar II, “Remarks to the National Kidney Foundation,” March 4, 2019. Available online at: <https://www.hhs.gov/about/leadership/secretary/speeches/2019-speeches/remarks-to-the-national-kidney-foundation.html>

*F. Supplemental Benefit Requirements (§§ 422.100 and 422.102)*

CMS proposes to codify prior sub-regulatory guidance on primarily health related supplemental benefits and uniform benefit flexibility.

**Recommendation:** We strongly support the codification of these provisions. We also recommend that CMS update relevant Medicare managed care manual chapters to include the revised policies and to provide examples of permissible benefits to promote common understanding and clarity.

*G. Rewards and Incentives Program Regulations for Part C Enrollees (§ 422.134 and Subpart V)*

CMS proposes to modify and clarify certain components of regulatory standards for the Part C Rewards and Incentives program.

**Recommendation:** AHIP strongly supports the use of rewards and incentives to encourage MA enrollees to be actively engaged in their health care and improve overall health and well-being. That is why we also continue to urge CMS to expand the rewards and incentives program to Part D benefits. We commend the step CMS is taking in the Proposed Rule to allow rewards and incentives for the use of the beneficiary real-time benefit tool. A broader availability of rewards and incentives in Part D could help to increase engagement between Part D plans and their enrollees and to improve enrollees understanding of Part D benefits, out-of-pocket costs, and clinically appropriate coverage alternatives.

*H. Requirements for Medicare Communications and Marketing (§§ 422.2260 – 422.2274; 423.2260 – 423.2274)*

CMS proposes to codify in regulation the guidance contained in the Medicare Communications and Marketing Guidance (MCMG). In the preamble, CMS indicates that with this codification, the agency intends “for the proposed regulations to closely mirror [] long-standing sub-regulatory guidance.” We appreciate CMS explaining its intention. However, we and our member plans have identified several discrepancies between the MCMG and the proposed regulatory text. For example, the proposed regulatory text states that “[w]hen a MA organization includes its customer service number, the hours of operation must be included the first time (at a minimum) the number appears,” in general communication materials. However, CMS’ August 6, 2019 guidance on the MCMG updates for CY 2020 deleted Subsection 30.4 that included the required display of hours of operation in materials.<sup>49</sup>

**Recommendation:** We recommend that CMS closely review feedback it receives on the proposed regulatory text to ensure that the final regulatory text aligns with language in the current MCMG. Consistent with CMS’ intention, the final regulatory text should also not impose any new restrictions on marketing or impose new marketing requirements that are not included in the current MCMG. We also ask that CMS provide the final marketing guidelines and related model documents soon after

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<sup>49</sup> [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare Communications and Marketing Guidelines Update Memo - 8-6-19.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare%20Communications%20and%20Marketing%20Guidelines%20Update%20Memo%20-%208-6-19.pdf)

release of the final Rate notice and include a specific date for the release of marketing guidance and related materials in the agency's annual MA and Part D calendar (e.g., early May). The release date for marketing guidance and model materials is an important factor and has a direct impact on plan operations and development of beneficiary materials.

*I. Past Performance (§§ 422.502 and 423.503)*

CMS proposes criteria the agency will use in determining whether to deny an MA or Part D application based on past contract performance. This proposal would replace the past performance review methodology. Specifically, CMS proposes to adopt three factors, each of which would be a basis for CMS to deny an application: 1) the imposition of civil money penalties (CMPs) or intermediate sanctions, 2) low Star Ratings scores, and 3) the failure to maintain a fiscally sound operation.

**Recommendation:** We do not support CMS' proposal for several reasons. Although we appreciate efforts to simplify past performance reviews, CMS' proposal would be too restrictive, raises equitable concerns, and necessitates more clarity and transparency. For example, low Star Ratings scores could be the result of events not under the control of the plan such as the possible impact of COVID-19. CMS should, therefore, not consider low Star Ratings as a determining factor to deny applications, including service area expansions. It is also important to keep in mind that audits that can trigger CMPs are not applied uniformly to all plans during the same period. As such, this proposal raises equitable concerns. More clarity is also needed regarding the CMP amount that would result in an application denial. CMS' proposal also does not indicate whether the agency would consider mitigating factors (e.g., implementation or completion of a corrective action plan) and provide plans with a remediation opportunity and an appeals process as part of its plan performance review, which we strongly recommend. In light of the number of concerns and questions raised above, we urge CMS not to finalize its proposal on past performance at this time.

# Proposed Rule Changes to the Medicare Star Rating Program

*Analyzing the Impact of Proposed Changes on Medicare Advantage Spending*

America's Health Insurance Plans

March 20, 2020

Developed by:  
**Wakely Consulting Group, LLC**

**Suzanna-Grace Sayre, FSA, MAAA, CERA**  
Senior Consulting Actuary

**Dani Cronick, FSA, MAAA**  
Consulting Actuary



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## Executive Summary

Wakely conducted a high-level analysis of the Star Rating program changes outlined in the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule<sup>1</sup> issued by the Centers for Medicare & Medicaid Services (CMS). This report includes estimates of the impact that the proposed changes in the Proposed Rule would have on Medicare Advantage Organizations' (MAO) Overall Star Ratings, and the resulting impact to Medicare Advantage (MA) spending. If adopted, the 2023 Star Rating changes will impact MA spending in the 2024 payment year. The proposed changes were each viewed in isolation as well as combined. While the report goes into greater depth, below are the key finding from this analysis:

### **Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0 would increase MA Spending by less than the CMS estimate.**

If this proposed change had been implemented for the 2020 Star Ratings, the change would be an increase to 2024 MA spending of \$83.0 million, or \$0.30 per member per month (pmpm), resulting in net cost to CMS. This value is far lower than the change of \$391.4 million that CMS estimated in the Proposed Rule. The approach we used to estimate this change matches the CMS methodology, with a few key differences.<sup>2</sup> The valuation of this change does not include consideration of other Star Rating changes, and we did not incorporate the addition, removal, or weight changes of other measures that will occur prior to the change in Patient Experience and Access Measures.

### **Deleting Tukey Outliers from the Clustering Methodology would decrease MA Spending by more than the CMS estimate.**

After incorporating the impact of mean resampling and cut point guardrails to the 2020 Star Ratings (a finalized change to go into effect in the 2022 Star Ratings), the incremental impact of Tukey outlier deletion would be a decrease to 2024 MA spending of \$1.4 billion, or \$5.24 pmpm, resulting in additional net savings to CMS. This value is significantly larger than the net savings of \$808.9 million estimated by CMS in the Proposed Rule. As with the change in Patient Experience/Complaints and Access measure weights, this estimate is based on Wakely's interpretation of CMS's methodology. Other than mean resampling and cut point guardrails, this estimate does not incorporate other finalized Star Rating changes.

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<sup>1</sup> <https://www.govinfo.gov/content/pkg/FR-2020-02-18/pdf/2020-02085.pdf>

<sup>2</sup> There may be several differences between the CMS and Wakely valuations, including but not limited to: a different base Star Rating year used to estimate the change (CMS used 2018, Wakely used 2020) and differences in 2024 enrollment and spending projections. Further detail around CMS and Wakely methodology and assumptions is included later in the report.

**The combined Star Rating System Changes would decrease MA Spending by more than the CMS estimate.**

After combining the two proposed Star Rating changes described above, the resulting impact is a decrease to 2024 MA spending of \$1.1 billion, or approximately \$4.10 PMPM<sup>3</sup>. This is a significantly larger figure than the net savings of \$417.5 million estimated by CMS in the Proposed Rule, and a significantly higher cost to the MAOs. Based on our analysis methodology, which considers the composite impact of the expected methodological changes to be implemented by 2024 payment year, it is possible that CMS has materially understated the impact to MA plan sponsors. While we acknowledge that the order of operations may influence component impact estimates, the aggregate estimated impact of proposed changes published in the Proposed Rule is materially lower than Wakely’s estimate.

As noted above, these estimates differ significantly from those published in the Proposed Rule. We attempted to match the CMS methodology in our estimates wherever possible. Table 1 summarizes the differences in these estimates. Note that the combined impact is less than the sum of the two proposed changes. When combined with the increase in Patient Experience and Access measure weights, the impact of Tukey outlier deletion is dampened as these measures become a smaller portion of weighting in the Overall Star Rating calculation.

**Table 1 – Differences in the Estimated Impact of Proposed Star Rating Changes**

Proposed Change	Impact to 2024 Medicare Advantage Spending	
	CMS Estimate	Wakely Estimate
Increasing Measure Weights	\$391.4 million	\$83.0 million
Tukey Outlier Deletion	\$(808.9) million	\$(1,443.8) million
Combined Impact	\$(417.5) million	\$(1,130.5) billion

**CMS has not provided enough information on methodology and assumptions for other parties to independently validate or recreate the results.**

There are several areas where CMS does not provide clarity on the methodology used to estimate the impact of these changes. A description of the items that are missing or unclear is included below in this report.

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<sup>3</sup> The combined estimate also includes the impact of Mean Resampling and cut-point guardrails on the 2020 Star Ratings.

## Introduction and Background

America's Health Insurance Plans (AHIP) retained Wakely Consulting Group, LLC (Wakely), to review the impact of the Star Rating changes in the Contract Year 2021 and 2022 Medicare Advantage and Part D Policy and Technical Changes to the Medicare Advantage Program (hereafter referred to as the "Proposed Rule"), issued by the Centers for Medicare & Medicaid Services (CMS) on February 18, 2020<sup>4</sup>. If finalized, CMS estimates that the proposed changes will result in an estimated \$4.4 billion in savings to the federal government over ten years. The majority of these savings arise from changes to the MA and Part D Quality Star Rating system.

The CMS Star Rating system was introduced in 2008 and began impacting MAO spending in 2012. The system is designed to measure two major components of Medicare Advantage (MA) and Prescription Drug Plans (PDPs): 1) the quality of health and drug services received by beneficiaries, and 2) the experiences of enrolled beneficiaries. Over the past few years, CMS has implemented several changes to the Star Rating system with the goal of improving accuracy and stability. Appendix 1 contains a summary of the finalized changes that will take effect in the 2021 and 2022 Star Rating years.

If adopted, the 2023 Star Rating changes described in the Proposed Rule would impact MA spending in the 2024 payment year. The changes include:

- **Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0.** This change represents an additional increase beyond the change finalized in the April 2018 rule, which increased the weights of these measures from 1.5 to 2.0. The majority of these measures are CAHPS surveys of health plan members. CAHPS surveys focus on the quality of care from the perspective of patients, such as access to care and care coordination issues. The increase in measure weights will impact the calculation of the overall and summary Star Ratings, not the measure-level Star Rating assignment.
- **Deleting Tukey Outliers from the Clustering Methodology.** As part of an ongoing effort to increase predictability and stability of the Star Rating system, CMS has proposed Tukey outer fence outlier deletion<sup>5</sup>. If implemented, the Tukey method will represent an additional step to the clustering methodology, to be applied prior to the application of mean resampling and five (5) percent guardrails. Removing contracts with outlier measure scores from the clustering methodology will impact the assignment of Star Ratings at the measure level as well as the calculation of the overall and summary Star Ratings.

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<sup>4</sup> <https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-and-2022-medicare-advantage-and-part-d-proposed-rule-cms-4190-p-1>

<sup>5</sup> The Tukey Outer Fence method flags observations outside of a range calculated as a multiple of the interquartile range, and designates these observations as "outliers". CMS has proposed a multiple of 3.0 to identify outlier data points.

- Remove the Rheumatoid Arthritis Management measure.** The National Committee for Quality Assurance (NCQA) is retiring this measure from the HEDIS measurement set for 2021 due to multiple concerns that the performance on the measure may not reflect the rate at which members get anti-rheumatic drug therapy. The removal of this measure will impact the calculation of the overall and summary Star Ratings.

## Comparison of CMS and Wakely Methodologies

Wakely attempted to match the methodology used by CMS to estimate the changes described in the Proposed Rule throughout this analysis, with a few key differences. Table 2 describes both known and unknown differences in data, methodology, and assumptions between Wakely estimates and the methods described by CMS in the Proposed Rule. These differences should be carefully considered before comparing Wakely and CMS estimates.

**Table 2 – Key Differences in CMS and Wakely Methodologies**

Method/Assumption	CMS	Wakely	Potential Impact on Results
<b>Mean Resampling and Guardrails</b>  Consideration for mean resampling and guardrails in the estimate of the proposed Tukey outlier deletion change	<b>Unclear</b>  CMS proposes to amend the outlier definition to apply Tukey outlier deletion prior to mean resampling and guardrails, which were already finalized in the 2019 Final Rule <sup>6</sup> .The estimate of Tukey outlier deletion does not clearly state whether the impact of mean resampling and guardrails is included.	<b>Yes</b>  Wakely applied mean resampling and guardrails to the 2020 Star Rating cut points prior to applying Tukey outlier deletion, therefore the estimate of the Tukey outlier deletion impact does not include the impact of mean resampling and guardrails.	<b>High</b>  Star Rating program changes have compounding impacts on results. Consideration for measure level changes set to occur would alter results.
<b>Deviation from Published Clustering Methodology</b>	<b>Unclear</b>  For several of the 2020 Stars measures, it does not	<b>Published CMS Cut Points</b>  Wakely used the published cut points	<b>Medium</b>  The Wakely estimate of Tukey outlier impacts may be

<sup>6</sup> <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>

Method/Assumption	CMS	Wakely	Potential Impact on Results
	appear that CMS uses the methodology published in the Star Ratings Technical Notes. These measures include C14, C29, C31, D04, and D09 <sup>7</sup> .	for these measures without any adjustments.	understated because we do not consider any changes to the cut point for these measures.
<b>Enrollment and Revenue Growth Assumptions</b>	<b>Unclear</b>  CMS only notes that the United States Per Capita Cost (USPCC) growth rates and county-specific quality bonus payments were used.	<b>Wakely 2024 Benchmark Rate Projections</b>  No explicit Enrollment Growth assumed vs. 2020 enrollment  Revenue growth assumptions include consideration of benchmark growth, future ACA caps, and current 2020 county-level contract enrollment.	<b>Medium</b>
<b>Base Data Cut Points</b>  Estimation of Star measure cut points on the base data, without considering any changes from the Proposed Rule	<b>Stars Measure Data for All Contracts</b>	<b>Stars Measure Data for Published Contracts Only</b>  CMS does not publish measure data for all contracts, therefore it is not possible for Wakely to match the published cut points exactly.	<b>Low</b>  Wakely normalized the results to account for the difference in derived cut points.

<sup>7</sup> C14 - Diabetes Care – Kidney Disease Monitoring, C29 - Members Choosing to Leave the Health Plan, C31 - Plan Makes Timely Decisions about Appeals, D04 - Complaints about the Drug Plan, D09 - MPF Price Accuracy

Method/Assumption	CMS	Wakely	Potential Impact on Results
<b>Star Rating Data</b> Data used for the analysis of Tukey outlier deletion, mean resampling, and guardrails	<b>2018 Star Rating Data</b>	<b>2020 Star Rating Data</b> Wakely utilized the most recent Star Rating Data that is publicly available.	<b>Unknown</b> Wakely did not test the impact of the difference in Star Rating data.

## Summary of Key Findings

Other than the known deviations described above, we attempted to replicate the logic CMS used to support estimations in the Proposed Rule. For a full description of our methodology and assumptions, see Appendix B. The following scenarios were tested in the order described below:

### Recalculated 2020 Star Ratings Cut Points Using the Public CMS Measure Data Set

It is not possible to replicate CMS’s cut point calculations exactly because CMS excludes some contracts’ Stars measure data from the published data set. To evaluate the impact of each Star Rating program change, we first ran the clustering methodology on the published 2019 and 2020 Star Rating measure data. This gave us slightly different results than the published 2019 and 2020 cut points. We used the new set of cut points in each subsequent step of Star Rating changes. This step was necessary to ensure that all subsequent changes to cut points determined using the published data – guardrails, mean resampling, and Tukey outlier deletion – were capturing only the impact of the Star Rating change, and not the impact of the difference between published Star Rating cut points and our calculations on the limited public data set. After applying the recalculated cut points, the total estimated 2024 MA spending changed by -0.4%. We then applied a contract-level adjustment to bring each contract back to its published Overall Star Rating for 2020. This method of normalization resulted in a set of contracts with the same contract-level and total 2024 estimated revenue as that which is implied by the published 2020 Star Ratings.

### Applied 2023 Star Rating Changes Described in the Proposed Rule.

- Increasing Patient Experience/Complaints and Access Measure Weights from 2.0 to 4.0.** There are currently 11 Part C measures and 7 Part D measures in the 2020 Star Ratings that are classified as Patient Experience/Complaints or Access measures. These measures are currently 33% of the Overall MA-PD Star Rating

weights. In the 2021 Star Rating year, these measure weights will change from 1.5 to 2.0, bringing their total weight to 40%. If implemented, changing the weight of these measures from 2.0 to 4.0 in the 2023 Star Ratings will bring these measure weights to 53% of the Overall MA-PD Star Rating.

If this change were implemented for the 2020 Star Ratings, without applying any other proposed 2021 and 2022 Star Rating changes, 16.5 percent of MA–PD contracts and 9.5 percent of members would have seen their Star Rating increase by 0.5 Stars, and 2.5 percent of contracts, as well as 3.9 percent of members, would decrease by 0.5 Stars. The net impact of these Star Rating changes is an increase of \$83.0 million (+\$0.30 pmpm) in estimated 2024 MA spending. As CMS mentioned in the proposed rule, this increase in MAO spending is due to plans more commonly performing more favorably on these measures.

- **Tukey Outlier Deletion.** Tukey outlier deletion removes data points that are deemed “outliers” from the data set before running the CMS clustering methodology. Because there are typically more low outliers than high outliers, this change would increase cut points and decrease measure-level Star ratings for many contracts.

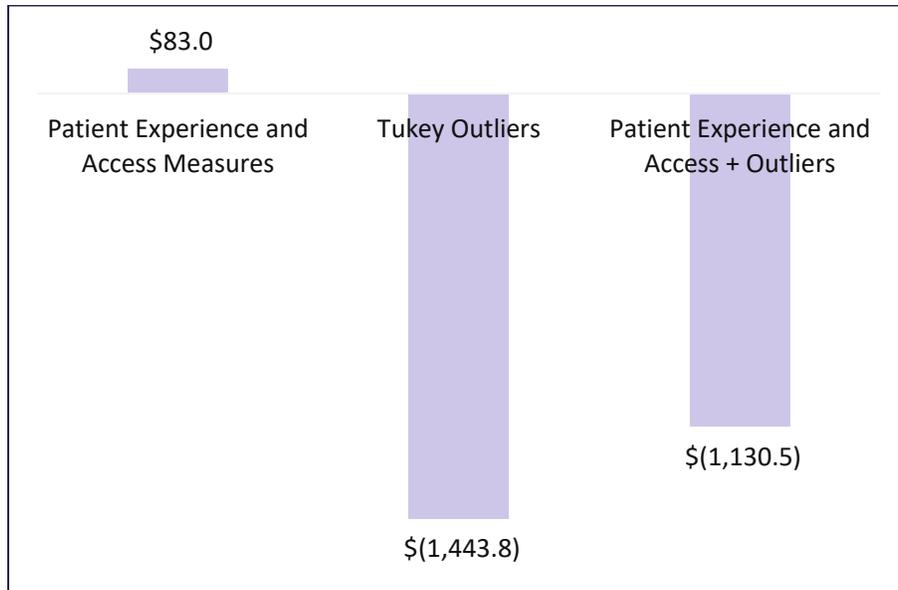
If this change were implemented for the 2020 Star Ratings, without applying any other proposed 2021 and 2022 Star Rating changes, 3.3 percent of MA–PD contracts and 11.9 percent of members would have seen their Star Rating increase by half a star, while 18.7 percent of contracts and 17.3 percent of members would have decreased by half a star. The net impact of these Star Rating changes is a decrease of \$1.4 billion (-\$5.24 pmpm) in estimated 2024 MA spending.

### **Combined All 2023 Star Rating Proposed Changes.**

The proposed Tukey outlier deletion change impacts various measures differently – specifically, this change would decrease non-CAHPS Star Ratings but would not have an impact on the CAHPS measures, many of which are also Patient Experience and Access measures. The result is an offsetting impact when these two changes are applied all together versus individually.

Figure 1 below shows the dollar impact that each Star Rating change is anticipated to have on MA spending, as well as the combined impact of both changes. Positive values indicate an increase in MA spending and additional costs for CMS. Negative values indicate a decrease in total MA Spending due to a particular Star Rating change, driving net savings for CMS.

**Figure 1 – Proposed Rule Changes, Impact to MA Spending**  
*Shown in millions*



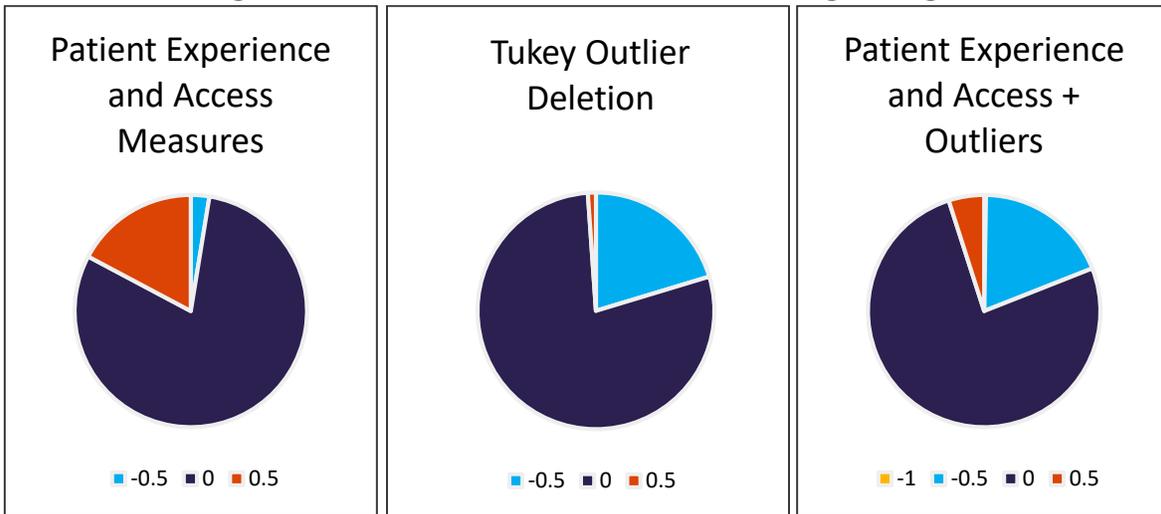
The combined impact of the Proposed Rule is a lower level of savings for CMS than if each change was evaluated separately. There is an offsetting impact between the change in cut-point methodology impacting all non-CAHPS measures and the increase in weight for Patient Experience and Access measures, many of which are CAHPS measures.

Figure 2 on the following page shows the distribution of contracts that improved 0.5 Stars, deteriorated by 0.5 Stars, deteriorated a full Star<sup>8</sup>, or stayed constant (0) under each proposed Star Rating change.

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<sup>8</sup> There was one contract that deteriorated a full star after the impact of both Patient Experience and Access Measures changing weight and Tukey Outliers being removed from the cutpoints.

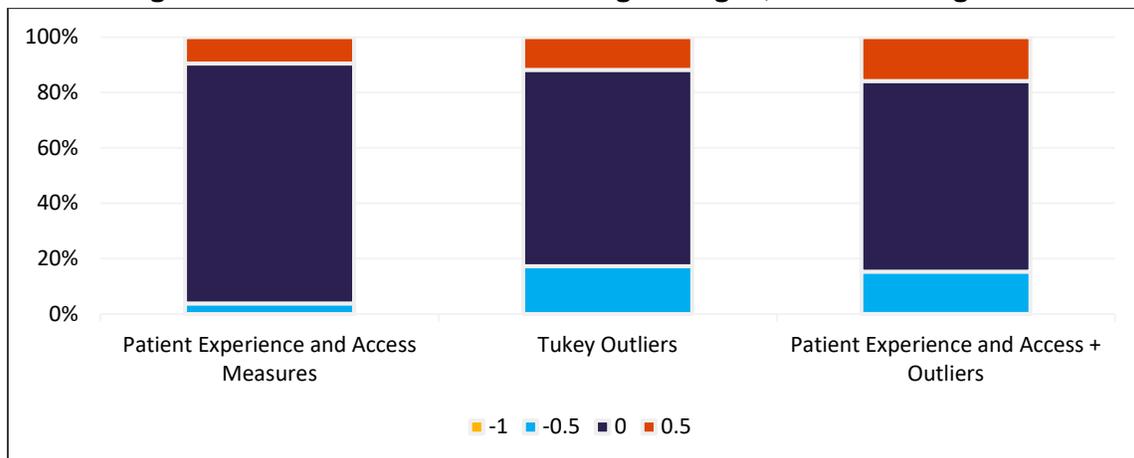
**Figure 2 – Distribution of Contract Star Rating Changes**



Note that the change in weighting for Patient Experience and Access Measures is favorable for more MAO contracts than it is unfavorable. On the other hand, almost a quarter of contracts will see a decrease in Star Ratings with the Tukey outlier change.

Figure 3 shows the distribution of members impacted by either an increase in half a star (0.5), a decrease in half a star (-0.5), a decrease in a full star (-1.0)<sup>9</sup>, or members who were not impacted (0). Overall, between the two changes more members are expected to be impacted by a decrease in contract Star Rating than an increase.

**Figure 3 – Distribution of Star Rating Changes, Member Weighted**



<sup>9</sup> Although it is not visible in Figure 2 or Figure 3, one contract with just over 2,000 members decreases by a full star after considering the impact of the Patient Experience and Access Measures and Tukey outlier deletion changes.

## Conclusion and Key Takeaways

Although the Wakely and CMS results differ due to known and unknown differences in methodology, our analysis suggests that the CMS quantification methodology may underestimate the negative impact of the Star Rating changes in the Proposed Rule.

**CMS has not provided enough information on methodology and assumptions for other parties to independently validate or recreate the results.**

There are several areas where CMS does not provide clarity on the methodology used to estimate the impact of these changes. In addition, CMS has estimated the impact of the proposed changes using an older data set (2018 Star Ratings), without updating for more recent MA plan sponsor performance in the Stars program. In order for stakeholders to fully understand and validate the impact to the Star Rating program, we respectfully request that CMS provide further documentation supporting the methodology for determining the published estimates in the Proposed Rule. In addition, we ask that CMS consider updating this analysis to use more recent Star Ratings data.

**CMS estimates in the Proposed Rule may underestimate the negative impact on MA spending of proposed changes to the Star Ratings program, potentially significantly.**

As illustrated throughout the report, the anticipated increase in MA plan sponsor spending driven by Patient Experience and Access measure changes is expected to be less than the CMS estimate, and the anticipated decrease in MA plan sponsor spending from the Tukey outlier deletion change is expected to be materially greater than the CMS estimate. In total, vs. the Wakely methodology, CMS may have understated the expected impact on MA plan sponsor spending in 2024 by more than \$700 million.

## Disclosures and Limitations

**Responsible Actuary** Suzanna-Grace Sayre and Dani Cronick are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

**Intended Users.** This information has been prepared for the sole use of the America's Health Insurance Plans (AHIP) and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We acknowledge that AHIP may provide the report to their

participating health plans. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their actuarial experts in interpreting results. This information is confidential and proprietary.

**Risks and Uncertainties.** The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. **Actual results may vary, potentially materially, from our estimates.** Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

**Conflict of Interest** We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent to AHIP.

**Data and Reliance** We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

**Subsequent Events** There are no known relevant events subsequent to the date of information received that would impact the results of this analysis. Differences or updates in the assumed contracts or risk and utilization of populations may cause deviation in results.

**Deviations from ASOPS** Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

## Appendix 1 – Finalized 2021 and 2022 Star Rating Changes

### 2021 Finalized Star Rating Program Changes

- Plan All Cause Readmission (Part C) to be temporarily removed while the measure is being updated
- All Patient Experience and Access Measures (Part C) to increase in weight from 1.5 to 2.0
- Recalculation of the Categorical Adjustment Index<sup>10</sup> (CAI) based on the latest plan performance data

### 2022 Finalized Star Rating Program Changes

- Adult BMI Assessment (Part C) to be removed
- Controlling Blood Pressure (Part C) to return to the Stars Calculation with a weight of 1.0
- Appeals Auto forward (Part D) to be removed – this is an Access measure that would have increased in weight for 2023 Star Ratings if it were not removed
- Appeals Upheld (Part D) to be removed – this is an Access measure that would have increased in weight for 2023 Star Ratings if it were not removed
- Cut point calculations to be updated with the additional process of mean resampling and adding 5% cut point guardrails

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<sup>10</sup> The Categorical Adjustment Index is intended to adjust contract level Star Ratings based on level of Low Income and Disabled enrollment in the contract.

## Appendix 2 – Methodology and Key Assumptions

### Methodology Overview

Wakely used the published 2019 and 2020 Star Ratings Data Tables<sup>11</sup> to evaluate the impact that specific changes to the Medicare Star Rating Program and calculations would have to Medicare Advantage Organizations (MAOs). These tables include measure level data (ex. a contract scoring 83% on the Breast Cancer Screenings measure), measure level Star Ratings (ex. a contract receiving 4 stars out of 5 on the Breast Cancer Screenings measure), Part C and D cut points for each measure, and Overall Star Ratings. We then replicated the CMS calculations for the 2019 and 2020 Overall Star Ratings for every contract by calculating raw Overall Star Ratings (weighting each measure with the CMS defined measure weight) and then adjusting for Part C and D Improvement Measures, Reward Factors, and the Categorical Adjustment Index (CAI).

With all contracts aligning in their starting point – Calendar Year 2020 Overall Star Rating – each of the changes in the Proposed Rule could be evaluated separately as well as together.

### Recalculating 2020 Star Rating Cut Points Using Public CMS Measure Data Sets

Wakely ran the clustering methodology on the published Star Rating measure data set to develop a new set of cut points for each Stars measure. Only the Stars measures that use clustering methodology were updated. All CAHPS measures use the relative distribution and significance testing methodology. There are no proposed changes to the relative distribution and significance testing methodology in the Proposed Rule, so Wakely used the published Star Ratings for these measures with no changes.

After developing a new set of cut points for each non-CAHPS measure, the results were then compared to the published 2019 and 2020 Star Rating cut points and checked for reasonability. For the majority of Stars measures, the new cut points were relatively unchanged from the published cut points. However, there were several measures with large cut point differences: Diabetes Care – Kidney Disease Monitoring, Members Choosing to Leave the Plan, Timely Decisions and Appeals, Complaints About the Drug Plan, MPF Pricing Accuracy, and the Part C and Part D Health Plan Quality Improvement measures. Wakely used the published cut-points for these measures without any adjustments.

To estimate the impact of recalculating cut points using published data, Wakely recalculated the Overall Star Ratings for every available contract using the revised 2020 Star Rating cut points.

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<sup>11</sup> <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData>

Next, all contracts were identified with changing Star Ratings between the published cut points and the simulated Wakely cut points. 20 percent of contracts had an Overall Star Rating decrease by half a star. For these contracts, half a star was added in order to adjust the Wakely base 2020 Star Ratings to match the published Star Ratings. This adjustment was also made in each subsequent change to the Star Rating program. After making these adjustments, the resulting data set was normalized to remove the impact of using cut points recalculated from the published data set.

## **Mean Resampling and Guardrails**

Wakely simulated the mean resampling and guardrail methods as described in the 2019 Final Rule to all of the non-CAHPS measures in the 2020 Star Ratings data set. The mean resampling and guardrail methods could have an effect not only on the current Star Ratings year but also on subsequent years. We accounted for this by simulating mean resampling on the 2019 Star Ratings data. The resulting cut points served as the reference point for applying the guardrail to the cut points obtained through applying both mean resampling and guardrails to the 2020 Star Ratings data. The 2020 Star Rating thresholds with mean resampling and a 5 percent guardrail were then simulated by referencing the simulated 2019 Star Rating cut points. The 5 percent guardrails were applied to all measures in the Part C and D Star Ratings program.

## **Patient Experience and Access Measures**

In the 2021 Star Rating year, CMS will increase the weight of all Patient Experience and Complaints Measures as well as the weight of all Access Measures from 1.5 to 2.0. Under the Proposed Rule, CMS would again increase these weights further from 2.0 to 4.0 in the 2023 Star Rating year.

In order to calculate the impact of Proposed Rule change, Wakely recalculated the Overall Star Ratings for every available contract using the revised weights of 4.0. Note that the change currently being proposed and evaluated is a weight change from 2.0 to 4.0, since the change from 1.5 to 2.0 has already been codified. The changing weights also impacted the calculated reward factor for all contracts. Reward factors were recalculated to reflect the change in weights; however, the impact that these changing weights would have on the Part C and Part D Improvement Measure was not considered for this analysis.

## **Tukey Fence Outlier Exclusion**

To improve stability in measure cut points over time, CMS has proposed to remove outliers using the Tukey Fence Outlier logic. This is a standard statistical method that identifies data points more than 3.0 times away from the outer quartiles. Values identified through Tukey outer fence

outlier deletion were then removed prior to mean resampling, and then clustering and the guardrails were applied.

To model this change, the clustering methodology was repeated after excluding any data-points identified as Tukey outliers and applying mean resampling. The change in cut points due to the outlier methodology was then applied to the current 2020 Star Rating cut points to establish new “Outlier” cut points, and guardrails were applied to limit the change between 2019 and 2020. Next, measure level data for all contracts and all non-CAHPS measures were compared to the cut points before and after the outlier exclusion and Overall Star Ratings were calculated.

One main simplification was made in this process. With the outlier changes, the Part C and Part D improvement measures would change based on changes to measure level Star Ratings. For this analysis, it was assumed that improvement measures would stay the same regardless of cut point changes.

## Revenue Impact

The above methodologies describe how changes in Overall Star Ratings were determined for all contracts based on the CMS proposed changes. The last step in the analysis was to quantify the resulting financial impact of these changes. Table B1 demonstrates the impact that Star Ratings have on MAO plan benchmarks and rebate percentages.

**Table B1: Quality Bonus and Rebate Percentages by Star Rating**

<i>Plan Rating</i>	<i>Bonus Payment</i>	<i>Quality Bonus Adjusted Benchmark</i>	<i>Rebate Percentage</i>
5.0	5.0%	105% of Benchmark	70%
4.5	5.0%	105% of Benchmark	70%
4.0	5.0%	105% of Benchmark	65%
3.5	0.0%	100% of Benchmark	65%
3.0	0.0%	100% of Benchmark	50%
<i>New Plans under New MAOs</i>	3.5%	103.5% of Benchmark	65%
<i>Plans Not Reporting</i>	0.0%	100% of Benchmark	50%

To quantify this impact, first Individual county-level benchmarks for 2021 through 2024<sup>12</sup> were determined for every 2020 contract at each Star Rating from 1.0 to 5.0. This involved utilizing

<sup>12</sup> Contract level benchmarks beyond 2020 assumed a constant county level enrollment distribution from 2020 forward.

published February 2020 county-level enrollment and Wakely internal county benchmark projections based on the known quartile changes, ACA benchmark caps, and current CMS benchmark projections. A bid estimate was derived for each Star Rating by applying an estimated bid to benchmark ratio to the contract level benchmark. The bid to benchmark ratios was developed at the county, product, and SNP type-level based on historic publicly available bids and benchmarks and trends in bid to benchmark ratios by quartile. Using this established bid and benchmark, the resulting MA revenue was then determined for all individual plans at each Star Rating.

Because Employer Group Waiver Plans (EGWP) do not submit a bid, the revenue for these plans at each Star Rating was determined by the EGWP payment rate. The revenue impact of a change in Star Rating, therefore, is based on the change in the payment rates based on Star Ratings.

Finally, the quantified revenue impact was multiplied by the estimated contract risk score. Risk scores were developed from 2017 publicly available data at the county, product, and SNP type level and were applied to the contract based on their enrollment distribution at the county, product, and SNP type level.

# Star Rating Variability of Patient Experience and Access Measures

*Analyzing the Impact of Variable Star Rating Cut Points and Measure Level Results*

America's Health Insurance Plans

April 3, 2020

Developed by:  
**Wakely Consulting Group, LLC**

**Suzanna-Grace Sayre, FSA, MAAA, CERA**  
Senior Consulting Actuary

**Dani Cronick, FSA, MAAA**  
Consulting Actuary



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## Executive Summary

Wakely performed an analysis evaluating changes in measure level cut points over time and the resulting impact on Star Ratings for Medicare Advantage Organizations (MAOs). The focus of this report is Patient Experience and Complaints measures as well as Access Measures. The Centers for Medicare & Medicaid Services (CMS) will increase the weight of these measures from 1.5 to 2.0 for the 2021 Star Ratings. In addition, CMS has proposed a further increase in these measure weights to 4.0 in the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule.<sup>1</sup> If implemented, these measures will have the largest weighting in the Overall Star Rating calculation. Below are the key findings from this analysis:

**Although measure level data and performance has been relatively stable for Patient Experience/Complaints and Access measures, measure-level Star Ratings have been volatile.**

After comparing average contract measure performance and Star Ratings, we determined contract Star Ratings are volatile year-over-year even while contracts have steadily improved in average measure values. This observation is particularly notable for Access Measures. The year-over-year change in cut points contributes to the observed volatility, and results in a disconnect between contract performance and contract scores, or Star Ratings.

**Increasing the weight of Patient Experience/Complaints and Access measures could introduce greater instability to the Overall Star Ratings.**

Our findings suggest that increasing the weights of the Patient Experience/Complaint and Access measures<sup>2</sup> will result in Star Ratings that are increasingly based on a set of measures for which there is evidence of material year-over-year volatility. The correlation between average contract performance and Star Ratings for these measures is unclear. Further study of the observed volatility and lack of correlation between performance and measure-level Star Ratings (based on current clustering methodology) is merited.

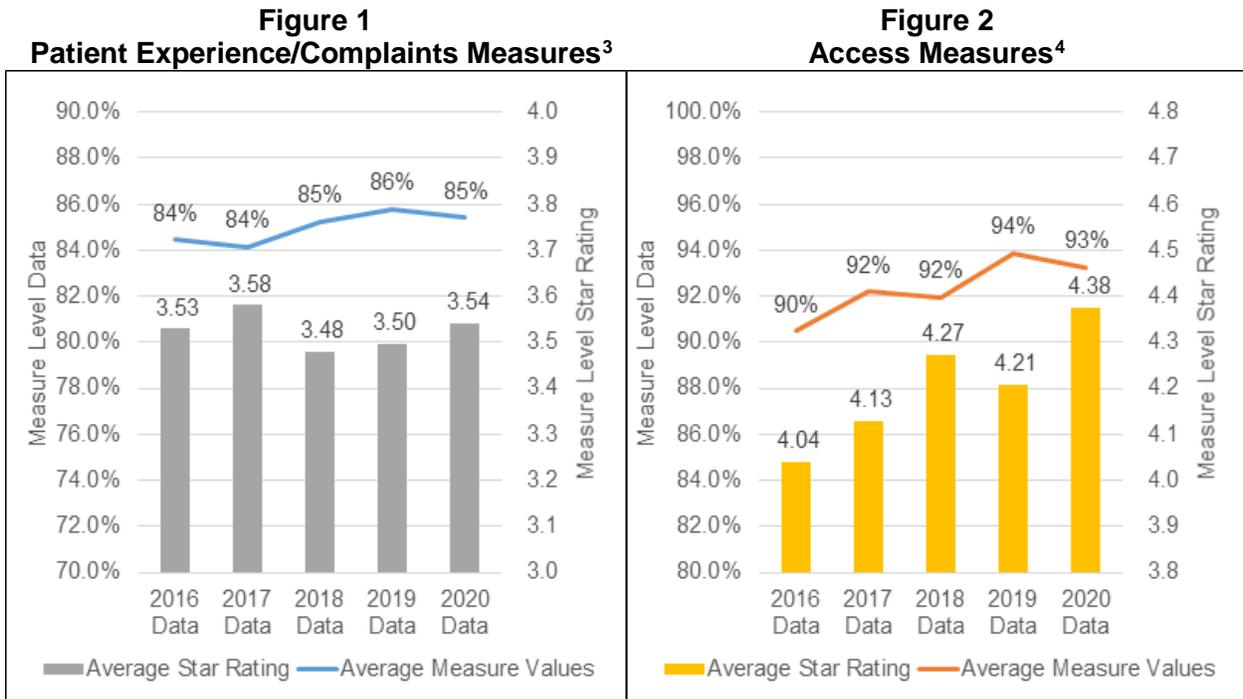
Figures 1 and 2 below demonstrate the volatility of these measures and disconnect between performance and ratings. All average results presented below are weighted equally across all contracts in order to be consistent with the weighting CMS uses in the clustering methodology. In other words, contracts are not weighted based on contract enrollment.

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<sup>1</sup><https://www.federalregister.gov/documents/2020/02/18/2020-02085/medicare-and-medicaid-programs-contract-year-2021-and-2022-policy-and-technical-changes-to-the>

<sup>2</sup> Throughout this paper, D02: Appeals Auto-Forward and D03: Appeals Upheld have been removed from summarized results because they will be removed from the Star Rating system beginning in 2022.





## Introduction and Background

The CMS Star Rating system was introduced in 2008 and began impacting MA spending in 2012. The system is designed to measure two major components of Medicare Advantage (MA) and Prescription Drug Plans (PDPs): 1) the quality of health and drug services received by beneficiaries, and 2) the experiences of enrolled beneficiaries.

The Star Ratings include measures applying to the following five broad categories:

1. **Outcomes:** Outcome measures reflect improvements in a beneficiary’s health and are central to assessing quality of care.
2. **Intermediate Outcomes:** Intermediate outcome measures reflect actions taken which can assist in improving a beneficiary’s health status.
3. **Process:** Process measures capture the health care services provided to beneficiaries which can assist in maintaining, monitoring, or improving their health status.
4. **Patient Experience and Complaints:** Patient Experience and Complaints measures reflect beneficiaries’ perspectives of the care they received.

<sup>3</sup> Patient Experience/Complaints Measures are sourced from CAHPS surveys and CMS administrative data.

<sup>4</sup> Access Measures are sourced from data collected by CMS contractors.

5. **Access:** Access measures reflect processes and issues that could create barriers to receiving needed care.<sup>5</sup>

In addition to these categories, the Star Ratings include Part C and Part D improvement measures derived through comparisons of a contract’s current and prior year measure scores across the majority of measures in the categories described above.

Table 1 shows the number of measures in each category under the 2020 Star Rating system, along with the weighting of each measure.

**Table 1 –Stars Measures, 2020 Star Rating System**

Star Rating Category	Number of Measures	Weight per Measure	Total Weight	% of Overall Star Rating
Outcomes	3	3.0	9.0	12%
Intermediate Outcomes	5	3.0	15.0	19%
Process	19	1.0	19.0	25%
Patient Experience and Complaints	10	1.5	15.0	19%
Access	6	1.5	9.0	12%
Improvement	2	5.0	10.0	13%

When combined, the Patient Experience/Complaints and Access measures represent 31% of the 2020 Overall Star Rating. CMS has proposed a significant weighting increase for these measures in the 2023 Star Rating system. Table 2 shows the proposed 2023 Star Rating weights for each measure category.

**Table 2 –Stars Measures, 2023 Star Rating System (Proposed)<sup>6</sup>**

Star Rating Category	Number of Measures	Weight per Measure	Total Weight	% of Overall Star Rating
Outcomes	3	3.0	9.0	8%
Intermediate Outcomes	5	3.0	15.0	14%
Process	19	1.0	19.0	17%
Patient Experience and Complaints	10	4.0	40.0	37%
Access	4	4.0	16.0	15%
Improvement	2	5.0	10.0	9%

If the weighting changes are implemented as outlined in the Proposed Rule, MAO contract performance in the Patient Experience/Complaints and Access measures will represent 52% of

<sup>5</sup> All results in this report exclude Access measures D02: Appeals Auto-Forward and D03: Appeals Upheld because CMS will remove these measures from the 2022 Star Ratings.

<sup>6</sup> With the exception of the two measures described above, this table contains only the proposed weight changes in 2023 and does not account for measures that will be added or removed between the 2020 and 2023 Star Ratings.

the 2023 Overall Star Rating. This is a significant increase, making the stability and predictability of these measures even more critical to ensure the stability of the Star Rating system.

America’s Health Insurance Plans (AHIP) retained Wakely Consulting Group, LLC (Wakely), to analyze the variability in measure level cut points and performance over time for the Patient Experience/Complaints and Access Measures. MAOs use Star Ratings to gauge their over performance relative to other contracts, and variability in the cut points makes it more difficult for contracts to track changes in performance over time and make it difficult to compare performance relative to industry benchmarks. Also, to the extent beneficiaries use the Star Ratings program to aid in choosing between MA plans during the annual open enrollment period, variability in the cut points can make it difficult for beneficiaries to easily compare performance between plans via Star Ratings over time.

The remainder of this report analyzes the changes in measure level cut points and the impact that these changes have on MAO Star Ratings.

## Summary of Key Findings

In order to observe the changes in contract quality performance and measure level Star Ratings, Wakely first gathered all available data from 2016 through 2020 Star Ratings and aggregated measure level performance, cut points and Star Ratings. For a full description of our methodology and assumptions, see Appendix A.

### Volatility of Measure Level Data and Scores

Although there was not significant volatility in actual contract performance over time, the measure level Star Ratings connected to these performance results did vary. Figures 1 and 2 from the executive summary demonstrate the changes in average measure level performance and Star Ratings over time, shown separately for Patient Experience/Complaints and Access measures.

The measure level values in each year were averaged across all contracts and measures within each of the two categories. The majority of measures are “higher is better” measures, where a higher value indicates better performance; however, there are a few measures where “lower is better”, i.e. a lower value indicates better performance. One example of these measures is C28: Complaints about the Health Plan. For these measures, we adjusted the values to:

$$\text{Lower is Better Adjusted Measure Value} = (1 - [\text{CMS Published Measure Value}])$$

After applying this change, we are able to combine the adjusted “Lower is Better” measure values with “Higher is Better” measure values in the same weighting category. We then calculate an average measure value across all contracts and all measures in the Patient Experience/

Complaints and Access measure categories.<sup>7</sup> We can also interpret an increase in the average measure value over time as an improvement, on average, in these categories.

Both Figures 1 and Figures 2 show there have not been large changes in average measure values between 2016 and 2020. The Patient Experience and Complaints Measures stay consistently between 84% and 86% in every year, and the Access measures show relatively steady improvement from 90% in 2016 to 93% in 2020.

Appendix B contains more detail on the historical performance of each Stars measure that contributes to the average Patient Experience/Complaints and Access measure values.

Figure 1 shows that average contract Star Ratings remained relatively unchanged for the Patient Experience and Complaints measures between 2016 and 2020. Although there have been slight changes in the unrounded average Star Rating each year, the rounded average Star Rating has remained at 3.5 every year.

Figure 2 shows that the average contract Star Rating for the Access measures has significantly more variability. The rounded average Star Rating varies from 4.0 in 2016, 2017, and 2019, to 4.5 in 2018 and 2020.

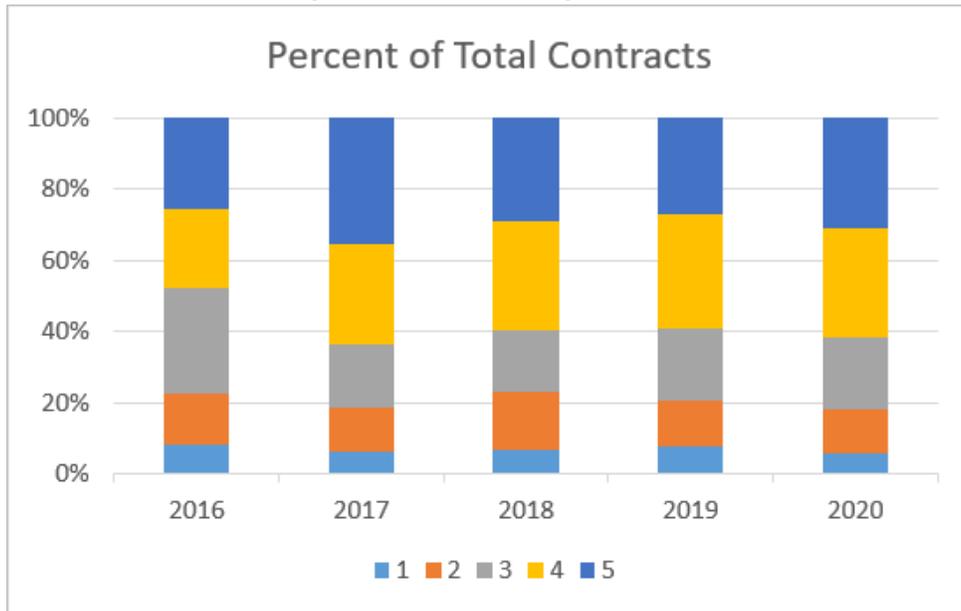
### **Contracts at each Measure Level Star Rating**

Along with the variance in average measure level Star Ratings, the portion of contracts receiving each Star Rating changes materially from year to year. Figures 3 and 4 represent the number of contract measures assigned to each Star Rating across all measures within the Patient Experience/Complaints and Access measure groups.

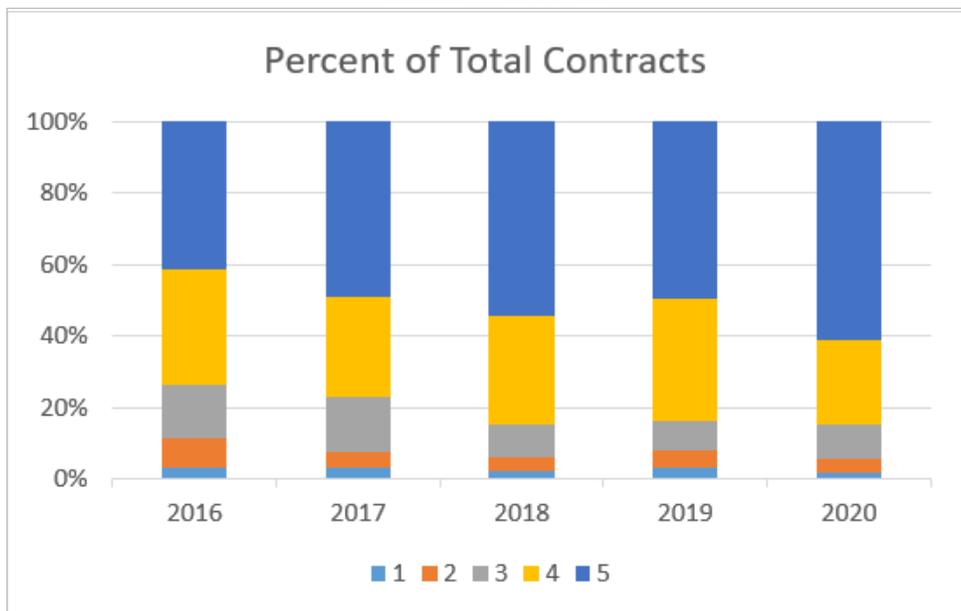
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<sup>7</sup> Measures that are on raw scale from 1 to 100 (rather than a percentage basis) were divided by 100 in order to maintain a consistent scale of 0 to 1 across all measures.

**Figure 3 – Percent of Contract Star Ratings Patient Experience and Complaints Measures<sup>8</sup>**



**Figure 4 – Percent of Contract Star Ratings Access Measures<sup>9</sup>**



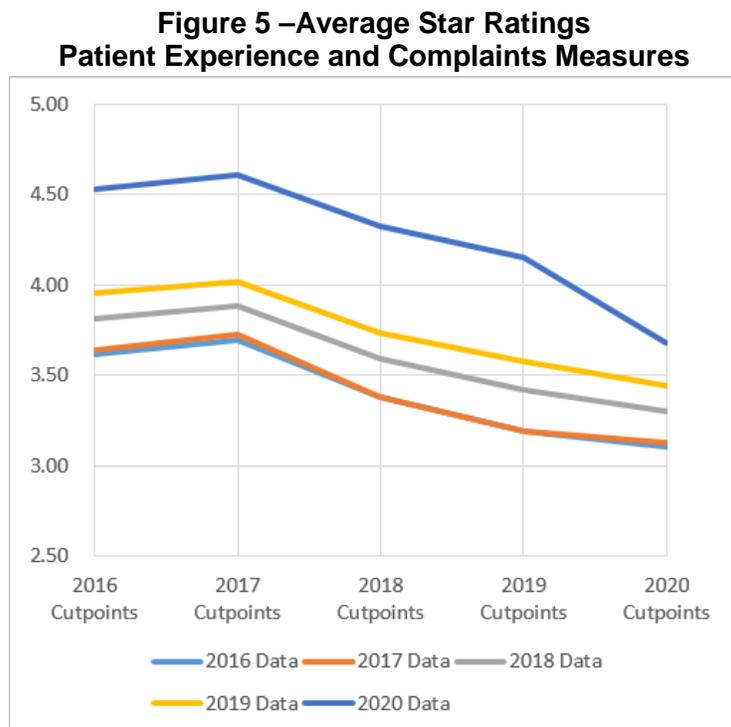
<sup>8</sup> Patient Experience/Complaints Measures are sourced from CAHPS surveys and CMS administrative data.

<sup>9</sup> Access Measures are sourced from data collected by CMS contractors.

Figures 3 and 4 illustrate the variability of Star Ratings from year to year. In particular, the portion of contracts that receive a 5.0 Star Rating varies widely each year. The portion of contracts receiving 5.0 Stars in Patient Experience and Complaints measures increased from 26% in 2016 to 36% in 2017, despite very little change in the weighted average value of these measures over the same time period from 84.4% to 84.2%.<sup>10</sup> Similarly, the Access measures experienced a small decrease in average value from 2017 to 2018,<sup>11</sup> but the portion of contracts with a 5.0 Star Rating increased from 49% to 55%. The volatility in contract Star Ratings is mainly driven by changes in cut points from year to year.

### Impact of Changing Cut Points on 2020 Contract Level Performance

Finally, we used the measure level data from 2016 through 2020 and applied the changing cut points over the same time period. The darker blue lines in Figures 5 and 6 below represent the 2020 measure data applied to the cut points in each Star Rating year from 2016 through 2020. For example, average contract performance in the 2020 Patient Experience and Complaints measures, using the 2020 cut points, resulted in an average Star Rating of 3.68, but this same level of performance would have resulted in an average Star Rating of 4.53 using the 2016 cut points.



<sup>10</sup> The change in average values described here is illustrated in Figure 1.

<sup>11</sup> The increase in average measure values is illustrated above in Figure 2.

**Figure 6 –Average Star Ratings  
Access Measures**

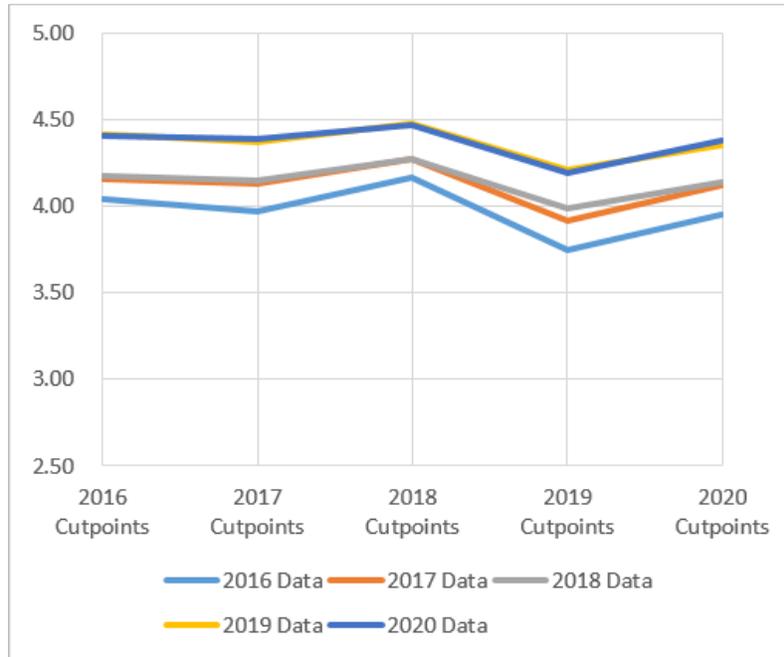


Figure 5 illustrates a significant decline in average Star Ratings for the Patient Experience and Complaints measures, even when keeping average contract performance in these measures constant. This large change over five years indicates the material impact of cut point changes on contract Star Ratings.

The Access measures trends in Figure 6 show a different pattern. Cut points for these measures have not steadily increased over time, and the average contract Star Ratings have increased or decreased in a seemingly random pattern each year, despite the fairly consistent improvement in measure level performance shown earlier in Figure 2. If an individual contract had consistent performance each year, its Star Rating would still increase or decrease purely due to cut point changes.

## Conclusion and Key Takeaways

With the proposed increase in weight to the Patient Experience/Complaints and Access Measures in the 2023 Star Ratings, these measures will become more heavily weighted than any other measure groups. It is critical to understand the drivers of historical cut point volatility in these measures, and how this volatility impacts overall Star Ratings.

**Historical cut point volatility in Patient Experience/Complaints and Access measures have contributed to volatility and inconsistent trends in contract Star Ratings.**

There has been significant year-over-year volatility in average Star Ratings for Patient Experience/Complaints and Access measures, despite relatively consistent trends in plan performance over time. This volatility is primarily driven by the use of the clustering methodology, which has resulted in cut points that are not well correlated to changes in contract performance each year.

**An increase in the weighting of Patient Experience/Complaints and Access measures could bring further instability to MAO Star Ratings.**

As the intended purpose of the Star Ratings program is to compare contract performance on measures related to beneficiary health outcomes and experience, increasing the weights for these measures has the potential to erode the stability of the Star Ratings program by basing the majority of the Star Rating score on measures that have historically shown significant Star Rating volatility despite relatively stable performance in measure level data.

## Disclosures and Limitations

**Responsible Actuary** Suzanna-Grace Sayre and Dani Cronick are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

**Intended Users.** This information has been prepared for the sole use of the America's Health Insurance Plans (AHIP) and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We acknowledge that AHIP may provide the report to their participating health plans. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their actuarial experts in interpreting results. This information is confidential and proprietary.

**Risks and Uncertainties.** The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. **Actual results may vary, potentially materially, from our estimates.** Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

**Conflict of Interest** We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent to AHIP.

**Data and Reliance** We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any

independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

**Subsequent Events** There are no known relevant events subsequent to the date of information received that would impact the results of this analysis. Differences or updates in the assumed contracts or risk and utilization of populations may cause deviation in results.

**Deviations from ASOPS** Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

## Appendix A - Methodology and Key Assumptions

In order to summarize the historical changes in measure level data as well as cut point and Star Rating changes, Wakely first gathered all publically available data for the 2016 through 2020 Star Ratings including measure level data, measure level cut points, measure level scores (Star Ratings), and overall Star Ratings. Because measures are added and removed over time, we focused the analysis on the most recent measures in the 2020 Star Ratings and compared performance using the same measures in prior years. Historical measures that were removed from the Star Rating system prior to the 2020 Star Rating year are not included in any of the summarized data presented in this report.

### Summarizing Measure Level Data

For the majority of this report, measure level data and results is summarized at the weighting category level. For some measures, higher values do not achieve a higher Star Rating (e.g., for Plan All-Cause readmission, having a *lower* rate is better, but for Breast Cancer screenings, having a *higher* rate is better). In order to aggregate across all measures within a given category, we made several adjustments.

For measures where “higher is better” and the measure is on a 0-100% scale, no changes were made. For measures where “lower is better”, we calculated an adjusted measure value equivalent to one minus the measure level rating. After making this adjustment, higher values consistently indicate better quality performance in all measures. Finally, for measures where the data is reported a whole number instead of a percentage (e.g., in the 2020 Star Ratings, “Getting Needed Care” is a number from 1 to 100), the measure data was divided by 100 to adjust contract performance to a scale equivalent with the other measures.

After applying these adjustments, contract level data was then summarized for each year using a straight average approach. The weighted average approach was used to best align with how members and Medicare Advantage Organizations would be impacted by these results. Enrollment was pulled from December of each Star Rating year. For 2020, February Enrollment was used.

### Applying Cut Points

After summarizing the publically available Star Rating data, we applied the measure level cut points for 2016 through 2020 to the measure level performance data from 2016 through 2020. The result was 25 different sets of measure level Star Ratings – 5 years of performance data times 5 years of cut points. The goal of this process was to determine:

1. If measure level performance were held constant over time (contracts did not have any improvement or deterioration in quality), how would their measure level Star Ratings change due to the changes in cut points alone?
2. If cut points were held fixed, how would measure level Star Ratings change over time due to changes in measure level performance alone?

For non-CAHPS measures, this involved selecting a period for the measure level data (e.g., in 2016 contract H1111 received 80% on the Breast Cancer Screening measure), and selecting a period for the measure level cut points (e.g., based on the 2018 cut points, an 84% would have yielded a 4 Star Rating for contract H1111 Breast Cancer Screenings Measure).

CMS applies a reliability factor to CAHPS measures that affects the assignment of measure level Star Ratings. It is not possible to calculate the reliability factor using the published Star Rating data, so we applied a simple calculation to derive the reliability factors. For each data year, the contract and measure level data for all CAHPS measures was compared to that year's measure level cut points and published measure level Star Ratings. When the resulting Star Rating did not match the published Star Rating, a reliability adjustment between -1 and +1 was derived to align the calculated Star Rating to the published Star Rating. This process was applied at the measure and contract level for all CAHPS measures, on all data years. The CAHPS reliability adjustment was then applied to the recalculated Star Ratings for every year (e.g., a 2016 CAHPS reliability adjustment was calculated based on 2016 data and 2016 cut points. This adjustment was then applied to the 2016 data with 2017 cut points, the 2016 data with 2018 cut points, and so on.). This approach assumes that the reliability factor remains constant even when measure level cut points change.

## Exclusions and Caveats

There were several exclusions that were made for the purpose of this report. The focus of this report is MAO contract performance, therefore we have excluded Part D Plans (PDPs) from the analysis.

## Appendix B – Measure Level Results

While the remainder of the report shows the change in average Patient Experience/Complaints and Access measures over time, this appendix illustrates each measure within these categories and the changes in measure level data and Star Ratings. The average amounts at the bottom of each table utilize the uniform metric described in Appendix A, where “Lower is Better” measures are inverted so that the average is one minus the published “Lower is Better” measure.

Figures B1 and B2 show the measure level data from 2016 through 2020 for Patient Experience/Complaints Measures and Access Measures.

**Figure B1 – Patient Experience and Complaints Measure Data**

Patient Experience and Complaints Measures	Data Source	Higher is Better?	2016 Data	2017 Data	2018 Data	2019 Data	2020 Data
C22: Getting Needed Care	CAHPS	Yes	83%	83%	83%	83%	83%
C23: Getting Appointments and Care Quickly	CAHPS	Yes	76%	76%	78%	78%	78%
C24: Customer Service	CAHPS	Yes	88%	88%	90%	90%	91%
C25: Rating of Health Care Quality	CAHPS	Yes	86%	86%	86%	86%	86%
C26: Rating of Health Plan	CAHPS	Yes	85%	84%	86%	86%	86%
C27: Care Coordination	CAHPS	Yes	85%	85%	86%	86%	86%
C28: Complaints about the Health Plan	CTM <sup>1</sup>	No	21%	24%	19%	17%	19%
C29: Members Choosing to Leave the Plan	MBDSS <sup>2</sup>	No	11%	11%	11%	10%	12%
D07: Rating of Drug Plan	CAHPS	Yes	84%	84%	84%	85%	85%
D08: Getting Needed Prescription Drugs	CAHPS	Yes	90%	91%	90%	90%	90%
<b>Average of All Patient Experience and Complaints Measures</b>			<b>84.4%</b>	<b>84.2%</b>	<b>85.2%</b>	<b>85.8%</b>	<b>85.4%</b>

<sup>1</sup> Complaints Tracking Module

<sup>2</sup> Medicare Beneficiary Database Suite of Systems

**Figure B2 – Access Measure Data**

Measures Capturing Access	Data Source	Higher is Better?	2016 Data	2017 Data	2018 Data	2019 Data	2020 Data
C31: Plan Makes Timely Decisions about Appeals	IRE <sup>3</sup>	Yes	94%	94%	92%	96%	96%
C32: Reviewing Appeals Decisions	IRE	Yes	89%	90%	89%	91%	92%
C33: Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	89%	93%	93%	94%	93%
D01: Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	89%	92%	93%	94%	92%
<b>Average of All Access Measures<sup>4</sup></b>			<b>90.5%</b>	<b>92.2%</b>	<b>92.0%</b>	<b>93.9%</b>	<b>93.2%</b>

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<sup>3</sup> Independent Review Entity

<sup>4</sup> D02: Appeals Auto-Forward and D03: Appeals Upheld were both removed from this analysis since they are Access Measures that will be removed from the Stars Calculation for 2022 Star Ratings

Figures B3 and B4 show the measure level Star Ratings from 2016 through 2020 for Patient Experience/Complaints and Access measures.

**Figure B3 – Patient Experience and Complaints Measure Star Ratings**

Patient Experience and Complaints Measures	Higher is Better?	2016 Star Ratings	2017 Star Ratings	2018 Star Ratings	2019 Star Ratings	2020 Star Ratings
C22: Getting Needed Care	Yes	3.5	3.3	3.4	3.3	3.3
C23: Getting Appointments and Care Quickly	Yes	3.4	3.3	3.3	3.4	3.4
C24: Customer Service	Yes	3.5	3.3	3.4	3.4	3.5
C25: Rating of Health Care Quality	Yes	3.4	3.4	3.4	3.3	3.3
C26: Rating of Health Plan	Yes	3.3	3.2	3.2	3.3	3.2
C27: Care Coordination	Yes	3.4	3.4	3.3	3.4	3.4
C28: Complaints about the Health Plan	No	3.9	4.6	4.3	4.1	4.9
C29: Members Choosing to Leave the Plan	No	4.2	4.3	4.0	3.9	3.9
D07: Rating of Drug Plan	Yes	3.3	3.3	3.2	3.2	3.0
D08: Getting Needed Prescription Drugs	Yes	3.4	3.6	3.4	3.5	3.5
<b>Average of All Patient Experience and Complaints Measures</b>		<b>3.8</b>	<b>3.53</b>	<b>3.58</b>	<b>3.48</b>	<b>3.50</b>

**Figure B4 – Access Measure Star Ratings**

Patient Experience and Complaints Measures	Higher is Better?	2016 Star Ratings	2017 Star Ratings	2018 Star Ratings	2019 Star Ratings	2020 Star Ratings
C31: Plan Makes Timely Decisions about Appeals	Yes	4.1	4.0	4.0	4.2	4.5
C32: Reviewing Appeals Decisions	Yes	3.6	4.0	4.0	4.0	4.1
C33: Call Center – Foreign Language Interpreter and TTY Availability	Yes	4.3	4.2	4.5	4.3	4.3
D01: Call Center – Foreign Language Interpreter and TTY Availability	No	4.2	4.3	4.5	4.3	4.6
<b>Average of All Access Measures</b>		<b>4.04</b>	<b>4.13</b>	<b>4.27</b>	<b>4.21</b>	<b>4.38</b>