November 30, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2022 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part I and Part II

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on Part I and Part II of the 2022 Medicare Advantage and Part D Advance Notice.

ACHP is a national leadership organization bringing together health plans and provider organizations that are among America's best at delivering affordable, high-quality coverage and care. Members are non-profit plans active in 35 states and the District of Columbia, providing both private and public coverage to nearly 22 million Americans. ACHP member companies offered nearly half of the health plan contracts awarded 5 stars in CMS' 2021 Star Quality Ratings and 41 Medicare Advantage contracts receiving at least 4 stars.

ACHP appreciates CMS' efforts to update Medicare Advantage payment modeling and accuracy and encourages CMS to continue exploring improvements to the Medicare Advantage program, and risk adjustment in particular, to achieve payment accuracy. It is imperative that health plans have the ability to strengthen benefits that meet the needs of enrollees and communities. The proposed changes for 2022 and enhancements to the Medicare Advantage and Part D programs are essential in light of the COVID-19 pandemic and a forecast of health care uncertainty.

Advance Notice Part I:

2020 CMS-HCC Model

ACHP supports CMS's proposal to fully transition to the 2020 CMS-HCC model and eliminate the supplemental use of RAPS inpatient diagnosis data. Full phase-in of this model will greatly reduce the administrative burden for both MA plans and for CMS,

allowing CMS to recalibrate the Part C risk adjustment model every year with the most currently available diagnoses and cost data.

ACHP recommends that CMS eliminate the coding intensity adjustment by moving towards using MA data to recalibrate the models. By fully transitioning to the 2020 CMS-HCC model, the statutory required coding intensity adjustment is becoming increasingly inaccurate. The 2020 CMS-HCC model incorporates several changes that are estimated to have significantly reduced or eliminated the coding differential between MA plans and Medicare fee-for-service. First, this model eliminates certain diagnosis codes that were suspected of being excessively coded by some MA plans. Second, the model incorporates differential risk scores for full versus partial Medicaid enrollees. MedPAC estimates of the impact of those changes indicates reduced risk scores by up to 3.5 percentage points -- bringing MA payments in line with Medicare fee-for-service payments for similar beneficiaries.[1]

Further, our experience indicates that the statutory minimum of 5.90% continues to be too high and negatively impacts ACHP member plans. While we understand the statutorily required coding intensity adjustment, the Social Security Act also provides that the "adjustment shall be applied to risk scores until the Secretary implements risk adjustments using Medicare Advantage diagnostic, cost, and use data" (codified in Sec. 1853(a)(1)(C)(ii)(IV)). ACHP believes this requirement will soon be met and therefore, we encourage CMS to eliminate the use of a coding intensity adjustment immediately.

COVID-19 Considerations

ACHP urges CMS to allow for greater flexibility for acceptance of diagnoses data from telehealth and audio visits. In these unprecedented times, this option is vital to protecting both the provider and patient from COVID-19. The pandemic has moved telehealth and audio visits to the forefront of medical care delivery and is a lifeline for millions. Many MA plans and Medicare providers will be unlikely to capture the appropriate diagnoses through typical office visits in these unusual times. It will be important that future risk adjustment models recognize this change in how medical care will be delivered going forward.

For the 2023 Payment Year, ACHP supports CMS develop Part C and Part D risk adjustment models that incorporate COVID-19 diagnoses and costs, and that the Part D model incorporate the costs of providing COVID-19 vaccines. We encourage CMS to develop new risk adjustment models that could be implemented as early as the 2023 payment year and incorporate COVID-19 factors. Because all the current MA and Part D risk adjustment models are prospective models, i.e., using diagnosis in current year and the costs in the following year, any recalibration of the current models would require data from the year 2020 for diagnoses and the year 2021 for costs. This would delay implementation of such a model to be at the earliest the year 2024. We therefore strongly recommend a

[1] MedPAC, March 2020 Medicare Payment Policy Report to Congress, Chapter 13, http://medpac.gov/docs/default-source/reports/mar20_medpac_ch13_sec.pdf

hybrid model configuration that would use a concurrent methodology for high cost acute diagnoses, in particular for COVID-19, and continue with a prospective model for the chronic diseases that are now currently incorporated in all the models. A concurrent methodology would use the diagnoses in the current year and the costs associated with those diagnoses that occur in the same current year.

Advance Notice Part II:

Risk Adjustment

ACHP recommends that CMS update the Part C risk adjustment models every year with the most current available diagnoses and cost data. CMS' Office of the Actuary stated that rebasing every year to account for the changes in county Medicare fee-for-service costs is increasingly important to update the models with more current data. This is particularly important given the faster-than-expected increases in Medicare fee-for-service risk scores in the past few years and the unknown financial and health ramifications of the COVID-19 pandemic. ACHP recommends that CMS move forward in exploring improvements in risk adjustment that can be achieved via a hybrid concurrent/prospective model rather than relying only on existing prospective risk adjustment model.

In addition, ACHP encourages CMS to ensure that the data lags are not suppressing the impact of Medicare age-ins between the denominator year and the payment year when developing the 1.000 risk score in the payment year. The retiring "baby boomer" generation is bringing about a demographic shift resulting in larger numbers of new, younger, and healthier enrollees. ACHP requests that CMS fully account for this healthier population in the projected normalization factors. Without this accountability, ACHP members are concerned the large normalization factor will not sufficiently reflect this demographic shift – especially given the 7-year lag between the denominator year (2015) and the payment year (2022).

ACHP recommends CMS fully rely on encounter data for both diagnoses as well as for estimating risk model coefficients as another approach to improving payment accuracy. Instead of the existing approach, which recalibrates coefficients using claims data from Medicare fee-for-service, CMS should work toward the development of a risk-adjustment model that uses encounter data for calibration. Such a model would eliminate the need for a coding intensity adjustment altogether. The model could be calibrated with MA utilization data and MA cost data from non-capitated plans, with the possibility of the cost data being supplemented by fee-for-service cost data where the MA encounter data does not contain spending information for services paid under capitated amount. Over time, as encounter data improves, the need for supplementation by fee-for-service cost data could decline.[2]

[2] MedPAC, June 2019 Medicare Payment Policy Report to Congress: http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf

ACHP recommends that CMS consider adjusting the normalization factor for past errors in prediction. As noted in previous comment letters, some of the Medicare fee-for-service risk trends in recent years may be due to a one-time event or a series of one-time events. For example, the conversion of ICD-9 to ICD-10, or the introduction of MIPs-related payment under MACRA could have increased risk scores, contributing to the appearance of a long-term trend. As a result, the resulting normalization factors likely are over-estimated. CMS should develop an adjustment for a historical over/under forecast of the previous year's normalization factor to be applied in the contract year's normalization factor. This same type of historical mis-forecast adjustment has always been part of the MA and Medicare fee-for-service growth rate calculation.

It is especially important that the forecast of the contract year's normalization factors be as up to date as possible because CMS currently does not correct for past years' forecasting errors. It is time for CMS to update the Part C models annually with the most current data to reduce the impact of the normalization factor and reduce the probability of mis-forecasting the ever-increasing normalization factor given the longer and longer timeframe between the denominator year and the payment year.

ACHP supports a reduction in all of the 2022 normalization factors because of likely change in FFS risk score trend due to pandemic. ACHP anticipates a change in the 2020 capture of diagnoses data for FFS (and MA) providers given the pandemic's impact on how outpatient care is delivered. This strongly suggests that 2020 could be an anomalous year for capturing diagnoses through physician office visits. Adjusting 2020 for this phenomenon will be difficult to estimate given the timing of not having 2020 FFS risk score data until sometime in 2021. CMS could look at the first nine months of 2020 FFS risk score data. We recommend CMS make a one-time adjustment downward to the FFS risk score trend that would lower the normalization factors knowing that physician outpatient health care has dramatically changed throughout 2020.

We also seek greater transparency regarding how Medicare age-ins whose risk scores 100% demographic factor are handled when resetting the 1.000 factor in the year of the model and then reset in the contract year. It is widely acknowledged that individuals aging into Medicare are healthier in general. We wish to ensure this population growth is factored into 1.000 calculation correctly in both years, and the 1.00 reset is not just done for the diagnoses portion of the risk adjustment models. The growth of age-ins should have a diminishing impact on the calculation of the normalization factor but this is not recognized in current forecasting.

Per our comments for the Advance Notice Part 1, ACHP encourages CMS to calibrate the Part C CMS-HCC risk adjustment model with more current fee-for-service data. If the model is recalibrated on a more frequent basis, forecasting a shorter time frame is easier and more predictable. The normalization factor "error difference" between actual and forecast would become much smaller because of shorter time frame that would be required to forecast.

<u>MA Benchmarks</u>

ACHP supports CMS' decision to not rebase the calculation of the 2022 county benchmark rates. ACHP agrees with CMS' decision given the COVID-19 impact on 2020 health care costs and the availability of accurate data to forecast 2022 county benchmarks. We applaud CMS' proposed effort to update historical county level Medicare fee-for-service costs in an earlier time frame and update these costs through repricing the claims with more updated Medicare fee-for-service schedules and payment rules.

Historical claims will be exclusive of the impact of the pandemic, including the significant change in how the health care system is handling other diseases and medical procedures in these difficult times. The county Medicare fee-for-service costs will not account for the significant changes and the geographic variation that are now occurring in utilization patterns and costs because of the pandemic. We are pleased to see the national growth rates are estimating the impact of the pandemic, and these same updates would, at a high level, adjust the county rates under a no rebasing assumption. In this unusual year, we believe it would be practical to make the simplifying assumptions that are associated with not rebasing – increasing the 2021 published county rates by the most recent forecast of the MA growth percentage.

More importantly, not rebasing will allow CMS to finalize the county benchmarks in the earliest time frame possible. An earlier final rate release would improve the development of bids, premiums and benefits that incorporate the uncertain of the impact of the pandemic.

If CMS decides to rebase, ACHP supports timeliness of the release of the rates over attempting to increase accuracy of rates with detailed updates of historical Medicare fee-for-service costs. ACHP supports the early release of the county benchmarks over the process of spending time and effort to update all the various factors that go into updating the county historical Medicare fee-for-service claims, e.g., repricing historical claims using latest pricing and fee schedules. The early release of the county benchmarks will assist plans in developing bids, premiums, and benefits in these uncertain times.

<u>MA Growth Rates, FFS Growth Rates, and MA Benchmarks</u>

ACHP strongly urges CMS to calculate MA growth rates and Medicare fee-for-service growth rates based on the costs of the fee-for-service beneficiaries enrolled in both Medicare Parts A and B. We agree CMS has the discretion to continue the long-time methodology of including beneficiaries who have Part A or Part B Only. However, if CMS is computing benchmarks used for MA bidding and payment rates, and the MA plans do not have this type of membership, then the benchmarks should not include this type of Medicare beneficiary and their costs. Excluding this type of beneficiary not enrolled in MA plans will make the comparison of the MA bid to benchmarks a more reasonable comparison. For example, the Office of the Actuary adjusts the county Medicare fee-for-service per capita costs for VA and DoD costs because these dual enrolled Medicare beneficiaries are not enrolled in MA plans.

County benchmarks should be calculated based on the costs of Medicare fee-for-service beneficiaries who are enrolled in both Medicare Parts A and B. ACHP is encouraged that there are reports that CMS will examine the impact of excluding the costs of the Part A-only Medicare fee-for-service beneficiaries from the county benchmark calculation for future plan years. As MedPAC recommended,[3] county benchmarks should only take into account individuals who are eligible for MA – those who have both Parts A and B coverage. The inclusion of Part A-only enrollees distorts the benchmark calculation because those enrollees have lower utilization and costs compared to enrollees in both Parts A and B. By including their costs in benchmark calculations, the resulting county benchmarks are reduced.

Because the presence of Part A-only enrollees varies by county, certain counties such as those with large numbers of federal retirees, are disproportionately impacted. Because both MA penetration and Part A only enrollment are increasing over time, the distortion of the benchmark calculation will grow as there are relatively fewer Part A and B enrollees included in the calculations.

ACHP urges CMS to base county benchmarks on a population with similar characteristics to that of the MA population. Such an approach is more actuarially sound than the current approach. In other formulas, CMS acknowledges the distortion that including Part A only beneficiaries would produce. Part A-only individuals are excluded in the calculation of Puerto Rico's benchmark. In addition, Part A-only FFS beneficiaries are excluded from risk adjustment calibration because of their different utilization and costs compared with the population enrolled in both parts of Medicare. Making such an adjustment would make CMS more consistent in calculating the components of plan payment by excluding Part A only enrollee from benchmark calculations.

Quality Incentive Payments

ACHP continues to recommend that CMS exclude quality payments from the benchmark cap calculation. CMS previously acknowledged that the quality bonus program does not adequately incentivize MA plans to continuously improve quality because the application of the benchmark cap policy reduces the quality payments going to many high-quality plans. According to MedPAC, this policy has resulted in the reduction or elimination of quality incentive payments in almost half of all counties for over 3 million beneficiaries. The loss of those quality incentive payments undermines value-based care, disincentivizes quality and diminishes benefits to seniors.

ACHP understands that CMS believes that the statute requires the benchmark cap calculation to exclude quality payments. However, ACHP previously provided CMS with a legal analysis of this statute that suggests CMS has flexibility under the statute to exclude the quality payments from the benchmark cap calculation. Correcting this interpretation

[3] MedPAC, March 2017 Medicare Payment Policy Report to Congress, Chapter 13, http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf?sfvrsn=0

aligns with Congressional intent and is essential for ensuring that seniors receive the highest possible quality of care.

Review the inclusion of Quality Bonus Payment (QBP) percentage for the ESRD for 4+ star MA plans. While ESRD beneficiaries will be allowed to enroll in MA plans starting in 2021, MA plans currently receive no quality bonus for coordinating the care for this high-cost population. The statute provides that the quality incentive payment should be applied at the contract or plan level, indicating that ESRD membership should be included in the quality incentive payment to MA plans. ACHP requests that the benchmark cap be calculated exclusively using ESRD data for ESRD benchmarks.

End Stage Renal Disease

ACHP recommends CMS analyze the impact on ESRD rates using smaller geographic areas. Under the 21st Century Cures Act, Medicare beneficiaries with ESRD are able to enroll in MA plans beginning in 2021. In preparation for their enrollment, it is important that CMS develop accurate and predictable ESRD rates. Volatility in ESRD costs, however, makes forecasting challenging and the implications of misestimating those amounts are concerning. Underpayment or inadequate rates could impact plans' ability to deliver high quality care, could result in increased premiums, and could reduce plans' ability to innovate in the services targeted to ESRD beneficiaries.

ESRD beneficiaries tend to be high users of high-cost services, accounting for 7.2% of the overall Medicare fee-for-service expenditures[4]. In addition to dialyses, hospitalizations are more frequent, and their use of physician and ancillary services are very high relative to the average enrollee. Further, the costs of those individuals can vary significantly between urban and rural areas of a state. Using statewide rates to estimate ESRD health care costs can under or over-state those costs significantly for any MA plan's given service area.

ACHP encourages CMS to examine whether the use of smaller geographic areas to estimate ESRD rates could result in improved payment adequacy and accuracy. As part of this analysis, CMS could explore the use of credibility adjustments for geographic areas with small ESRD fee-for-service enrollment to improve such rates. For example, CMS could examine the application of a credibility adjustment to the data using a methodology parallel to that used for MA Part C and D bids for plans with low enrollment.

Star Measure Ratings

ACHP supports CMS' proposed enhancements in Star Ratings measures overall and particularly, measures of patient reported outcomes and non-opioid pain management.

ACHP urges CMS to discontinue use of the improvement measures which distort the Star

[4]United States Renal Data System. 2019 USRDS annual data report: epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2019. https://www.usrds.org/media/2371/2019-executive-summary.pdf

Ratings and are unnecessary given that the entire purpose of the Star Ratings system is to incentivize improvement. A separate measure of improvement blurs the distinction between high-performing plans that have little room for improvement and those plans which have more significant opportunities to get better.

ACHP continues to request that CMS consider, for the 2022 plan year and forward, including a measure of consistency for high performing plans. Such a measure would reward consistency and stability in performance over time. This would promote Star Ratings more appropriately based on performance across the entire range of clinical, patient experience and administrative/compliance measures.

COVID-19 vaccine

ACHP member plans anxiously await the Food and Drug Administration's approval of COVID-19 vaccine(s) and the subsequent distribution and administration to Medicare members. However, we recommend CMS wait to add this question to the CAHPS survey or collect utilization via another measure until more is known about potential variations in availability and distribution among the individual states, potential changes in CDC recommendations and immunity duration. In addition, any new measure based on COVID-19 vaccination must account for enrollees who do not receive the vaccine due to availability, prioritization decisions or personal objections.

Provider Directory Accuracy

ACHP has the following concerns regarding a provider directory accuracy stars measure. First, we are concerned that the existing CMS review process for MA plan provider directories is subjective and discourages CMS from including this as a Star Ratings measure. Second, CMS currently encourages MA plans to work with providers and the National Plan & Provider Enumeration System which could eventually be used as a single source of provider data accuracy. Adding a provider directory measure disincentivizes use of this system due to creating competition between MA plans and their ability to achieve a quality bonus. Third, MA plans across the country contract differently and each arrangement presents different challenges with provider data accuracy. A provider directory accuracy measure could inadvertently favor one contracting type over another. While ACHP agrees with CMS' goal to ensure up-to-date and accurate information is available to Medicare beneficiaries as a priority for all insurers, we recommend CMS allow health plans the flexibility to perform information quality assurances for their beneficiaries.

Thank you for consideration of ACHP's comments and recommendations. We appreciate the Administration's efforts to support and improve the Medicare Advantage and Part D programs. Please contact Michael Bagel, Director of Public Policy at mbagel@achp.org or 202-897-6121 with any questions or to discuss our recommendations further.

Regards,

Ceci Connolly
President and CEO
ACHP