March 1, 2022

The Honorable Chiquita Brooks-LaSure, 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) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the 2023 Medicare Advantage and Part D Advance Notice. We support CMS' efforts to update Medicare Advantage payment modeling and accuracy and encourage CMS to continue exploring improvements to the Medicare Advantage program, in particular risk-adjustment and quality. It is imperative that health plans have the ability to strengthen benefits that meet the needs of consumers and communities. The proposed changes for 2023 and enhancements to the Medicare Advantage and Part D programs are essential in response to the continued impact of the COVID-19 pandemic.

ACHP represents the nation's top-performing non-profit health plans improving affordability and outcomes in the health care system. ACHP member companies are provider-aligned health organizations that provide high-quality coverage and care to more than 24 million Americans across 36 states and D.C. They are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data driven systems improvement.

ACHP welcomes the opportunity to ensure the evolution of the MA program that fosters competition on a level playing field to best serve seniors. As part of that evolution, the pandemic has shown the value and success of virtual care for beneficiaries within the MA program and we look forward to CMS supporting its continued success. We offer the following comments to support a robust Medicare Advantage and Part D program for the more than 27 million seniors already enrolled and the thousands that join the program each day.

Quality Payments Benchmark Cap

ACHP continues to strongly recommend that CMS exclude quality payments from the benchmark cap calculation. This is a longstanding priority for ACHP and our members. We encourage CMS to consider the impact on health plans' ability to improve coverage and care for their communities and its impact on the larger Administration goal to support health equity. Consider two high quality MA plans in neighboring counties: Plan A receiving the full quality bonus while Plan B is not because of the pre-ACA benchmark cap in that county. This limits Plan B's ability to provide comparable benefits and premiums to consumers within that county, despite both being

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high-quality plans. ACHP understands that CMS has argued 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 shows CMS has flexibility under the statute to exclude the quality payments from the benchmark cap calculation. Correcting this interpretation aligns with Congressional intent and is essential for ensuring that seniors receive the highest possible quality of care. Correcting this issue also eliminates significant payment inequity. We feel obliged to reiterate, quality payments do not sit in the health plans' bank account but must be used to expand benefits or reduce premiums. These dollars serve Medicare beneficiaries.

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 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 three million consumers. The loss of those quality incentive payments undermines value-based care, disincentivizes quality and diminishes benefits to seniors.

Sources of Diagnoses for Risk Score Calculations for CY 2023

ACHP strongly recommends CMS allow for greater flexibility for acceptance of diagnoses data to account for risk suppression during the pandemic. CMS acknowledges that the data collected in 2020 resulted in lower than anticipated risk scores for 2021. ACHP also predicts some level of risk suppression will be evident in 2021 data and have a similar impact on 2022 risk scores. Consistent with CMS' conclusion of the data in 2020 and to account for future anomalous years, ACHP recommends CMS either allow health plans to use encounter data from audio-only visits or allow a 24-month lookback to carry forward existing diagnoses for 2020 and 2021. The lookback approach could be limited to certain diagnoses and diseases. Either of these changes would capture risk score data for chronic conditions that would have otherwise been accounted for. Without this flexibility many MA plans and providers are unlikely to capture the appropriate diagnoses through typical office visits despite continuing to provide care and benefits for beneficiaries to properly manage their HCC conditions.

CMS-HCC Risk Adjustment Model for CY 2023

ACHP supports a timelier recalibration of the Part C CMS-HCC Risk Adjustment Model. The 2020 CMS-HCC Model uses a denominator year of 2015 as compared to the upcoming payment year of 2023, an eight-year gap. ACHP recommends CMS update this model so there is no greater than a 4-to-5-year gap between the denominator year of the model and the payment year. This will better reflect beneficiaries more recent utilization and spending trends in the health care delivery system.

ACHP is very supportive of CMS' intent to enhance the risk adjustment model to incorporate social determinants of health (SDoH). However, ACHP cautions that the SDoH data collection initiative alone is a significant undertaking and not yet ready for inclusion in risk adjustment models or quality measurements. We encourage CMS to evaluate other geographic breakdowns as zip codes are arbitrarily set for the United States Postal Service and do not adequately reflect social needs. We look forward to opportunities to work with the Administration in evaluating the most appropriate data for incorporating SDoH in risk adjustment to improve our understanding of beneficiary risks and needs.

Medicare Advantage Coding Pattern Adjustment

ACHP supports the continued application of the statutory minimum of 5.90%. The 2020 CMS-HCC model incorporates several changes that are estimated to have significantly reduced or eliminated the coding differential between MA plans and fee-for-service (FFS) – MedPAC estimates reduced risk scores by up to 3.5 percentage points, bringing MA payments in line with Medicare FFS payments for similar consumers.[1]

Further, our experience indicates that the statutory minimum of 5.90% continues to be too high and negatively impacts ACHP member plans and the seniors they serve. ACHP requests CMS recognize that the coding intensity adjustment does not "level the playing field" and results in inappropriately low or negative risk scores for many nonprofit regional health plans. While we understand the statutorily required coding intensity adjustment, the Affordable Care 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 strongly encourages CMS to study the use of MA data for recalibration so that CMS can eliminate the use of a coding intensity adjustment in the immediate future.

ACHP recommends CMS move to a risk adjustment model based on MA encounter data for diagnoses and estimating risk model coefficients to improving payment accuracy. Such a model would eliminate the need for a coding intensity adjustment. 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 would decline.[2]

Normalization Factors

ACHP recommends CMS reconsider the Part C 2020 CMS-HCC Model FFS to negate the need for a normalization factor in CY 2024. ACHP understands why CMS chose to not use 2021 risk scores for the normalization factor calculation. The third year of the pandemic continues to affect traditional care delivery and we expect additional anomalous years of risk scores. If CMS were to take up ACHP's earlier recommendation to transition to a risk adjustment model solely based on encounter data, this would eliminate the need for a normalization factor. CMS would no longer need to make such accommodations as proposed for CY 2023 in recognition of risk score data affected by the pandemic. If CMS did not make this transition, significant modification would need to be made to contend with including risk scores for 2021, 2022 and potentially 2023 in the traditional 5-year quadratic equation methodology for calculating normalization.

Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2023

ACHP continues to request CMS exclude Part A only and Part B only beneficiaries for the USPCCs used to develop MA capitation rates. Since MA plans cannot enroll Part A only or Part B only members, these beneficiaries and their costs should be excluded, consistent with MedPAC's recommendation. It is important to make this adjustment to have USPCCs reflective of MA beneficiaries, especially as the percentage of Part A enrollees continues to increase year over year.

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

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

Calculation of the Fee-for-Service (FFS) Cost by County

ACHP requests CMS eliminate Part A only and Part B only beneficiaries FFS costs for establishing county benchmarks. As MedPAC recommended,[3] county benchmarks should take into account only those individuals who are eligible for MA – those who have both Parts A and B coverage. According to Kaiser Family Foundation (KFF)[4], in 2021, at least 42% of Medicare beneficiaries (26.4 million out of 62.7 million) are enrolled in Medicare Advantage. There are 446 counties in which MA enrollment is more than 50% of the total county Medicare consumers. Including Part A only and Part B only distorts the county's FFS costs, particularly in high MA penetration counties. The Office of the Actuary currently 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. While an immediate change would be most appropriate, CMS could implement a phased-in approach for counties with MA penetration of over a certain percentage and gradually lower the threshold with subsequent Rate Notices.

MA ESRD Rates

ACHP supports CMS studying and eventually implementing ESRD rates at a smaller geographic level than the state level. ESRD beneficiaries tend to be high users of high-cost services, accounting for 7.2% of the overall Medicare fee-for-service expenditures[5]. In addition to dialyses, hospitalizations are more frequent, and their use of physician and ancillary services are very high relative to the average aged/disabled enrollee. Underpayment or inadequate rates could impact plans' ability to deliver high quality care, could result in increased premiums, reduced benefits, and could reduce plans' ability to innovate in the services targeted to ESRD beneficiaries. ESRD rates impact the ability of a MA plan to deliver high quality care to all of its enrollees.

ACHP requests CMS examine the possibility of the inclusion of Quality Bonus Payment (QBP) percentage for the ESRD for 4+ star MA plans. 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.

Rebasing/Re-pricing

ACHP supports the preliminary release of an "estimate" of rebasing the county rates at the time of the Advance Notice. CMS was able to release the Final Notice on January 15, 2021 with final MA benchmarks, indicating this is possible moving forward. A preliminary rebasing at the time of the Advance Notice improves our member companies overall bidding process allowing better estimates for their contract year premiums and benefits. This would also benefit the employer group market as requests for preliminary or final rates early in the MA bidding cycle are common.

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[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

[4] Kaiser Family Foundation (KFF), Medicare Advantage in 2021: Enrollment Update and Key Trends, M. Freed, J. F. Biniek, A. Damico, and T. Neuman. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/

[5] 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

COVID-19 Considerations for Future Risk Adjustment Modeling

ACHP recommends CMS develop Part C and Part D risk adjustment models that incorporate COVID-19 diagnoses and costs when recalibrating future risk adjustment models. We encourage CMS to develop new risk adjustment models that would incorporate the COVID-19 disease burden for CY 2024. As COVID-19 is not a chronic disease allowing for cost predictions in the following year, ACHP recommends a concurrent risk adjustment model for COVID-19 diagnosis. This would evaluate current year diagnoses, developing risk adjustment coefficients for the costs in the same year. The ESRD transplant risk adjuster model provides precedent for this model as it follows this timing - MA plans are paid for the costs of the transplant in a given year, and not for the following year's costs.

Quality Measures – Potential New and Proposed Modifications

Health Equity Index and Driving Health Equity
ACHP supports the Administration's goal to incentivize better data collection and evaluation to close health equity gaps, however, we encourage a gradual approach to any required measurement collection and inclusion in Star Rating measures. ACHP member plans are evaluating current internal processes on how to collect, store, organize and analyze necessary data, all of which takes significant time and resources to modify existing infrastructure. We also encourage the Administration to align with the NCQA Health Equity Accreditation program as health plans are already taking steps to meet accreditation criteria. Should CMS move forward with this proposal, ACHP does not support replacing the reward factor with a health equity index, reiterating our stance that this data collection requires significant operational processes that need to be vetted prior to such a proposal. We agree with the need for improved data collection and evaluation, but ACHP is concerned that a rapid approach to data collection and measurement may noy produce the most successful behavior modification incentives to truly incent closing equity gaps and improving health outcomes.

Assessment of Beneficiary Needs and Screening and Referral for Social Needs
ACHP does not recommend CMS develop a measure for the Assessment of Beneficiary Needs. NCQA is already developing a measure that assesses Screening and Referral for Social Needs. ACHP member plans perform screening for beneficiary needs in a variety of ways that best suit the needs of the communities and populations they serve – as a one size fits all approach does not work in many instances. ACHP members also serve a variety of populations with significant geographic differences that affect the availability and delivery of social need services. This would be particularly difficult to capture with quality measures. We acknowledge the need for standardizing this data, but urge CMS to explore alternative pathways, including Z-codes, for SDoH standardization before developing new measures.

Improvement Measures
ACHP urges CMS to discontinue use of the improvement measures which distort the Star 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. We look forward to working with the Administration to identify additional opportunities to modernize the Star Ratings program.

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