March 6, 2023

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) 2024 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 2024 Medicare Advantage and Part D Advance Notice. We support the update to the Medicare Advantage (MA) risk-adjustment model and encourage CMS to continue exploring improvements to the MA program, particularly raising the bar on star ratings and quality. We are committed to working with CMS to enact policy changes that improve the program, increase access and competition, and keep the focus on delivering results for consumers.

While numerous health plans support moving forward with the entire new risk-adjustment model next year, CMS must recognize that the magnitude of the proposed changes are significant and highly variable. As a result, many plans feel strongly that circumstances necessitate additional time and further information and are requesting a one-year delay of the reclassification portion of the risk-model update. It remains imperative that health plans maintain the ability to strengthen benefit design and value-based care delivery that meet the needs of consumers and communities. CMS should work closely with health plans to move forward with the timely implementation of a revised risk-adjustment while mitigating the impact on consumers.

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 deliver high-quality coverage and care to tens of millions of Americans across 37 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 be a leader in the next generation of MA to foster competition on a level playing field, raise the bar on quality performance and further equity to best serve seniors. We offer the following comments to support a robust Medicare Advantage and Part D program for the more than 30 million seniors already enrolled and the thousands that join the program each day.

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CMS-HCC Risk-Adjustment Model for 2024

ACHP supports a timelier recalibrating of the Part C CMS-HCC Risk Adjustment Model to include updating underlying fee-for-service data years and updating the denominator years used in determining the average per capita predicated expenditures. Using more recent underlying data years and updating the denominator will better reflect consumers' more recent utilization and spending trends in the health care delivery system. CMS should continue to regularly update the underlying fee-for-service years to reduce the sensitivity of the model to coding variation and reflect more recent physician practice patterns. Over the past several years, fee-for-service has continued to more comprehensively document beneficiary acuity, reducing the perceived gap with MA. As this trend continues, it is important to update the years in the model to reflect the closing of the risk-adjustment documentation gap between beneficiaries enrolled in fee-for-service and MA.

ACHP requests CMS delay implementation of the new clinical reclassification of HCCs in the V.28 model for one year to provide sufficient time to understand the new model and prepare for its implementation. CMS is already proposing significant changes to the risk-adjustment model in updating the years used for model calibration and updating the denominator year used for predicted expenditures. Both of those changes are timely and important to make.

ACHP recommends CMS provide additional information and transparency into the reclassification model methodology. While ACHP supports clinical reclassification that maps to ICD-10 codes, CMS has not provided sufficient time to analyze and understand the proposed approach. To provide comprehensive feedback, our member companies require additional time for analysis. ACHP requests CMS provide further details and technical notes – such as predictive ratios stratified by beneficiary cohorts which has been previously provided – into the underlying data utilized to calibrate the new V.28 classification. This will allow health plans to simulate the proposed model revisions and provide meaningful feedback. In implementing any changes to the risk adjustment model once finalized, we recommend that CMS consider the potential for significant disruption to value-based contracts and plan benefit offerings and ways to ease the transition to the new model.

As part of the proposed reclassification, ACHP member companies have noted a disproportionate, and potentially unintended impact, on health plans serving predominantly dual eligible beneficiaries, contrary to CMS' commitment to improving health equity. Within the short amount of time afforded to understand the proposed model changes we cannot identify the underlying cause of that impact and look forward to continuing our analysis to provide CMS necessary insight to inform changes before this portion of the updated risk-adjustment model is implemented. We also remain concerned that changes to specific diagnosis groups – for example diabetes and vascular disease – may negatively impact efforts to target interventions and health care benefit design for this critical population.

ACHP is committed to a MA risk-adjustment system that accurately and appropriately accounts for the acuity of each consumer. CMS should continuously refine the risk adjustment model to appropriately align incentives for documenting diagnosis codes with those clinical conditions most predictive of future health care spending and address underlying incentives to aggressively document. The goal of risk-adjustment should be to provide the necessary resources to care for each consumer while encouraging high quality and coordinated care delivery.

In addition to the risk-model changes proposed, ACHP looks forward to partnering with CMS outside of the Advance Notice process on a larger effort to reduce risk-adjustment burden, target aggressive documentation practices and use targeted auditing to address bad actors.

Risk Score Trend Methodology

ACHP is concerned with CMS portraying the entire health plan industry as growing average risk scores by 3.30% in 2024. While CMS has routinely claimed that health plan risk score trend is between 2.0 – 3.5% annually, CMS has yet to produce a methodology or share its assumptions for how this growth rate is generated. ACHP member companies, committed to coding completely and ethically, have risk score growth that is significantly below the reported CMS risk score trend. **ACHP requests CMS provide back-up justification for its risk score tend growth, clearly articulate that this assumption is an average across all contracts and provide a range based on the 25th and 75th quartile of risk score trend to show the significant variance across the industry.** CMS should also utilize this information to target program integrity efforts at those carriers with risk score trends above industry average and reduce burden on compliant health plans that are appropriately utilizing the risk-adjustment system.

Quality Measures – Raising the Bar and Creating Consistency Across Federal Programs

Universal Measure Set

ACHP is pleased that CMS is seeking comment on quality measurement as part of an overarching effort to create a "universal foundation" to align quality measures across federal programs. In *Health Care 2030: ACHP's Roadmap to Reform,*[1] ACHP called for a 21st century quality measure approach that standardizes metrics for all federal health programs – Medicare, Medicaid, Exchanges and the Federal Employee Health Benefits Program. We recognize that for health plans, providers and consumers to prioritize meaningful measurement and meaningful health outcomes, the quality program must be simplified, and synergies created across the entire health ecosystem. ACHP strongly supports a set of quality metrics that apply to as many quality-rating and value-based care programs as possible. This will reduce provider burden, allow for measurement across and between programs and populations to target interventions and drive quality improvement for all consumers regardless of the federal program through which they receive their health care benefit.

ACHP looks forward to closely partnering with CMS on the selection of measures included in the universal foundation. It is important that CMS focus on patient experience and outcomes measures rather than topped-out process measures that are part of standard medical practice. We recommend that any process measure be focused on screening and prevention that allows for meaningful differentiation in performance.

CMS should contemplate how to improve measure collection at the forefront of establishing a universal foundation measure set. Current survey tools, particularly CAHPS, do not accurately reflect patient experience and outcomes, disproportionately impacting consumers with significant health equity or social needs. Current survey tools are not designed or operationalized in ways to measure experience variance by population segment and therefore result in reduced participation from an already too-small sample.

[1]Health Care 2030: ACHP's Roadmap to Reform (September 2020); https://achp.org/roadmap-2030-achp-report/

Health plans and providers should not be negatively impacted for supporting minority, low-income or hard-to-reach consumers because of misalignment in survey tools. We look forward to working with the Administration to improve the process to ensure the new universal foundation of measures are appropriately and comprehensively collected across all communities and consumers.

Improvement Measures

ACHP recommends CMS 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 towards stellar performance and good health of the population. 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. While the improvement measure may have served a laudable purpose in the early years, it is outdated and rewards some of the lowest-performing actors. Seniors deserve *consistently* high quality and performance, not accidental or coincidental modest improvements.

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 from the formula, consistent with MedPAC's recommendation and CMS' tacit acknowledgement that the current benchmark formula is incorrect. In the Medicare Data for Geographic Variation Public Use File: A Methodological Overview, CMS states for the study population that beneficiaries are excluded if they were enrolled at any point in the year in Part A only or Part B only because spending for those beneficiaries cannot be compared directly to spending for beneficiaries that are enrolled in both Part A and Part B.[2] ACHP agrees. CMS should be consistent and exclude Part A only and Part B beneficiaries in developing MA capitation rates. 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.

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, in 2022, at least 48% of Medicare beneficiaries (30.2 million out of 65.2 million) are enrolled in Medicare Advantage. There are fifteen states in which MA enrollment is more than 50% of the total state Medicare consumers and growing. Including Part A only and Part B only distorts the county's FFS costs, particularly in high MA penetration counties.

[2] Medicare Data for the Geographic Variation Public Use File: A Methodological Overview. February 2023 Update. https://data.cms.gov/sites/default/files/2023-02/d30ee401-edd4-4d41-a631-69d95356dc2d/Geographic%20Variation%20Public%20Use%20File%20Methods%20Paper.pdf

[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

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 over a certain percentage and gradually lower the threshold with subsequent Rate Notices.

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 does 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 high-quality plans.

ACHP recognizes 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 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 are 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. The loss of those quality incentive payments undermines value-based care, disincentivizes quality and diminishes benefits to seniors.

Medicare Advantage Coding Pattern Adjustment

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.[4] ACHP urges CMS to engage early and regularly with all stakeholders on development of this new model, including proposing its changes through notice and comment rulemaking to ensure robust and comprehensive feedback before its implementation.

Rebasing/Re-pricing

ACHP supports the preliminary release of an "estimate" of rebasing the county rates at the time of the Advance Notice. A preliminary rebasing at the time of the Advance Notice improves the overall bidding process allowing better estimates for 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.

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, Associate Vice President 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

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