February 29, 2024

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) 2025 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 *CY 2025 Medicare Advantage and Part D Advance Notice*. We commend the Administration's efforts to make improvements in the Medicare Advantage (MA) program that now provides coverage for more than half of Medicare beneficiaries. We encourage CMS to continue exploring improvements to the MA program, particularly leveling the playing field of risk adjustment, raising the bar on star ratings and quality and finalizing broker compensation proposed changes. 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.

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 nearly 40 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 continues to lead proactive reforms for the next generation of MA through our *MA for Tomorrow* initiative. We maintain our unique support for CMS' modifications to the risk adjustment program, moving to v28, to allow physicians to focus on care over documentation and remove perverse incentives that prioritize risk over quality. We raise three key comments in response to the *CY 2025 Advance Notice*:

1. ACHP is concerned that the impact of an ongoing COVID-19 rebound is not adequately taken into consideration. This rebound has profound implications for both the effective growth rate and normalization factor.
2. ACHP encourages additional reforms to MA risk adjustment to improve the evaluation and representation of health plans with risk scores and risk score growth well below the national average. A number of these reforms are central to ACHP *MA for Tomorrow* initiative.
3. ACHP does not support the proposal for separate Part D Normalization factors for MA-PDs and PDPs. We also recommend modifications to the Part C Normalization factor methodology to improve representation of the COVID-19 pandemic and it's rebound.

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We offer the following additional comments to support a robust Medicare Advantage and Part D program for the more than 32 million seniors already enrolled and the thousands that join the program each day.

Effective Growth Rate

ACHP is concerned that the estimated effective growth rate does not adequately reflect the uptick experienced in Quarter Four utilization. Health plans across the country continue to experience the rebound effect from the COVID-19 pandemic in addition to an uptick in drug related expenses, driven by GLP-1 demand. The combination of increased acuity (acute public health events and increased disease prevalence) and the ongoing utilization recovery in a post-pandemic environment continues to drive cost trends significantly above 2022 and early 2023 levels. **ACHP requests CMS reflect this increase in utilization in the CY 2025 Final Rate Notice. ACHP also requests CMS provide greater transparency into the drivers of year-over-year changes to the growth rate.**

2025 Risk-Adjustment

CMS-HCC Risk Adjustment Methodology

ACHP supports CMS' continued phase-in of the v28 CMS-HCC Risk Adjustment Model. The transition will improve risk adjustment across the industry and promote responsible and more equitable risk adjustment practices.

ACHP continues to recommend CMS calibrate the risk adjustment model to use only MA encounter data. It is past time to calibrate the MA program's risk model using only MA encounter data. 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. With this methodology, 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.

RxHCC Risk Adjustment Methodology

ACHP is concerned that Part D demographic factors and coefficients continue to understate plan liability for under 65 dual eligible SNP plans. Even with the improvement in risk scores for low-income individuals due to the new RxHCC Risk Model, ACHP member companies are anticipating DNSP plans becoming too expensive to offer without adjustment of the risk model. Initial estimates show the highest cost for Part D beneficiaries with excessive plan liability. **ACHP requests CMS adjust the risk model to account for the highest need individuals with the highest drug costs in certain eligibility categories.**

Risk Score Trend Methodology

ACHP is mystified by CMS's assertion that the entire health plan industry is growing average risk scores by 3.86% in 2025. **ACHP requests CMS produce the methodology or assumptions for how this growth rate is generated.** Our member companies, committed to coding completely and ethically, have risk score growth that is significantly below the reported CMS risk score trend and raises serious questions regarding outliers that must be driving the average up significantly.

ACHP's *MA for Tomorrow* also includes policy recommendations to address the discrepancy between the actual risk growth of ACHP member companies and the higher risk growth industry trend. In lieu of a risk adjustment model based solely on encounter data, ACHP recommends tiering the coding intensity adjustment to account for differential coding practices. An in-depth review of regional health plan risk scores clearly shows significantly lower scores and year over year risk score growth. An across-the-board coding intensity adjustment acutely impacts these types of health plans while producing only marginal impacts for health plans with risk scores well over 1.0 and growth rates close to the CMS projected 3.86%.

ACHP also recommends CMS target risk adjustment data validation (RADV) audits on health plans with higher likelihood for coding abuses indicated by significant risk adjustment deviation from the industry average or regional average.

Part C and Part D Normalization

Part C Normalization Factor

CMS' proposed modifications to the Normalization Factor methodology assume post-COVID-19 risk score growth stabilization well above pre-COVID-19 trends. However, ACHP member companies continue to experience rebound effects in utilization and costs. ACHP is concerned that the proposed updates will over-adjust for risk growth in future years due to the inclusion of years impacted by the COVID-19 rebound effects. ACHP member companies are also seeing provider coding changes as a result of increased coding scrutiny. This is leading to more conservative coding practices, further driving down risk scores in circumstances where that behavior change may not be warranted.

ACHP recommends that CMS maintain the current linear methodology. Should CMS maintain this methodology, ACHP recommends using a five-year average but subtracting COVID year 2020 and 2021 (using years 2017-2019, 2022-2023).

If CMS finalizes the multivariate methodology, we urge the agency to assign COVID indicator factors to 2022 and 2023. This recommendation is derived from a recent Wakley white paper, "*A Deeper Look at FFS Normalization in the CY 2025 Medicare Advantage Advance Notice."*[1] These COVID indicators either can be derived by taking the ratios of the 2022 and 2023 year-over-year trends to the average from 2016/2017 through 2020 for v24/v28 or set at 0.60/0.30 for 2022/2023. According to the Wakley analysis, this yields normalization factors between -1.3 and -0.8% for v24 and v28 relative to those proposed in the Advance Notice.

ACHP also notes that the directional impact of the CMS-HCC version 28 risk adjustment model should lessen the need for normalization if the model works as intended. **Given the new risk adjustment model, the post-COVID care rebound and the proposal to use a more involved methodology to determine normalization, ACHP supports CMS pausing proposed changes to the normalization factor methodology until some of these other factors resolve or stabilize.**

Part D Normalization Factor

ACHP does not support separate normalization factors for MA-PD plans and PDP plans. ACHP is concerned about the specific impact to the low-income (LIS) subsidy population and the

[1] https://www.wakely.com/sites/default/files/files/content/deeper-look-cy2025-part-c-ffs-normalization-factor.pdf

broader impact given the transition to a new risk model. Recent analysis shows a change in the percent of LIS enrollees within PDP market (i.e. LIS enrollment is decreasing) and MA market (i.e. LIS enrollment is increasing).[2] The trend of LIS enrollees selecting MA-PD plans offers an alternative explanation for increasing risk scores within the MA-PD plans, as opposed to increased risk scores due to coding. This analysis also highlights that average risk scores for SNP MA-PD is higher than non-SNP and PDPs. ACHP is concerned with including SNPs in the calculation of a separate MA-PD normalization factor when SNPs are not included in national average bid amount.

Fee-for-Service Growth Percentage

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. ACHP agrees. CMS should be consistent and exclude Part A-only and Part B-only 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-only enrollees continues to increase.

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, county benchmarks should only account for those individuals who are eligible for MA – those who have both Parts A and B coverage. According to Kaiser Family Foundation, in 2023, at least 51% of Medicare beneficiaries are enrolled in Medicare Advantage.[3] As of 2023, twenty-eight states had MA enrollment of at least 50% of total 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 over a certain percentage and gradually lower the threshold with subsequent Rate Notices.

Medicare Wage Index

Several ACHP member companies are in regions that experienced a significant increase in the Medicare wage index following the 2024 IPPS final regulation. While the wage index change is budget neutral nationally, the regional impact has a disproportionate impact on community plans in areas that experienced a large increase. These community plans are unable to distribute the impact over large geographic regions. ACHP requests CMS account for these wage index variations in the individual county-level benchmarks for 2025 provided in the Final Rate Notice.

[2] MAST Health Policy Solutions Analysis of 2020 Part D Payment Risk Scores and Enrollment Data from CMS.
[3] https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/

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 member companies. 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 include 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.

Thank you for your consideration of ACHP's comments and recommendations. We appreciate the Administration's efforts to support and improve the Medicare Advantage and Part D programs. ACHP appreciates the Administration's engagement on *MA for Tomorrow* and applaud the action taken on our broker compensation recommendation. 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
Alliance of Community Health Plans

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The Honorable Chiquita Brooks-LaSure, Administrator
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RE: Draft CY 2025 Part D Redesign Program Instructions

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the draft Part D Redesign Program Instructions for 2025. ACHP and its member companies are proud to have supported the passage of the Inflation Reduction Act with holistic drug pricing reforms and are committed to ensuring successful implementation. We continue to actively support CMS' efforts to ensure people with Medicare benefit from lower prescription drug bills.

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ACHP's comments focus on three key provisions within the draft program instructions and urge the rapid finalization of the instructions for consideration as bids for CY 2025 are finalized.

1. **Costs Counted Towards True Out-of-Pocket Costs (TrOOP)**
2. **Policy for Drugs Not Subject to Defined Standard Deductible**
3. **Medicare Prescription Payment Plan**

Costs Counted Towards True Out-of-Pocket Costs (TrOOP) – ACHP member plans appreciate the additional clarity and definitions and urge CMS provide standard communication for beneficiaries around which amounts are included and excluded in the calculation.

Policy for Drugs Not Subject to Defined Standard Deductible – ACHP urges prescription drug event reporting instructions with additional examples of the Discount Program be released as soon as possible to allow for consideration in formulary design for CY 2025.

Medicare Prescription Payment Plan – ACHP reiterates its comments in response to the Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans: Draft Part One Guidance on Select Topics. Our member companies face operational challenges and intricacies, enrollment and disenrollment issues and billing and payment processing challenges. These concerns were further highlighted in "Medicare Part D's New Prescription Payment Plan May Not Reduce Costs For All," Health Affairs Forefront, February 8, 2024. We recognize CMS intends to finalize part one and part two and ask that such

information, including instructions for treatment of bad debt resulting from this program, be made available as soon as possible to overcome the significant challenges of planning and implementation. Additionally, we encourage CMS to provide plans with a year to identify and correct systems issues because of the payment plan without impact to Stars ratings. Forwarding Complaints Tracking Module data to plans will aid the implementation process.

Thank you for your 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
Alliance of Community Health Plans