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Cynthia Tudor, PhD
Acting Director, Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via email to: AdvanceNotice2018@cms.hhs.gov

**RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter**

Dear Dr. Tudor:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the 2018 Advance Notice and Call Letter.

**Summary**

Before presenting our specific comments, we would like to highlight several issues and concerns about the 2018 Advance Notice and Call Letter:

- **Quality Incentive Payments:** ACHP urges CMS to finally correct the substantial losses to America's seniors from implementation of the benchmark cap. CMS can use new authority granted in the President's executive order of January 20, 2017 to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act" that imposes a burden, cost, or penalty on individuals, families, health plans, and others. We have previously provided legal analysis documenting how the law provides discretionary authority, and that authority is strengthened further by the executive order. CMS' interpretation to date has reduced or eliminated quality payments to plans in about half the nation's counties. That in turn has cost tens of millions of dollars in Medicare benefits to about 2.5 million seniors who enrolled in high quality plans so they could take advantage of enhanced benefits. It is time to fix this problem for the 2018 plan year.

- **Using A/B Enrollees to Determine FFS Costs:** As the Medicare Payment Advisory Commission (MedPAC) has documented, Part A-only FFS beneficiaries have very different utilization and cost patterns from those who enroll in both A and B. And the Part A-only beneficiaries are a growing segment of the FFS population, particularly in counties with high MA penetration. Including Part

A-only enrollees in the calculation of county FFS costs significantly underestimates those costs, which in turn drives MA benchmarks lower than they would be if the appropriate comparison group – A/B enrollees only – were used. While we recognize there are questions to be considered, ACHP asks that CMS recalculate the USPCC and county benchmarks using the A/B enrollees only, per the forthcoming MedPAC recommendation.

- **Employer Group Waiver Plans (EGWPs):** ACHP opposes further phase-in that would use individual bid-to-benchmark ratios to calculate the Part C base payment for EGWPs for the 2018 payment rates. CMS generally has provided gradual transitions for this kind of change; using 100 percent of the individual bids in 2018 represents too abrupt a payment change for MA plans with large EGWP enrollment. In addition, the proposed methodology for 2017 is complicated and requires further study. We recommend retaining the 50/50 blend of individual and EGWP bids for 2018 as CMS studies alternative methods.

- **Coding Intensity Adjustment:** We appreciate that CMS has decided not to increase the coding intensity adjustment beyond the statutory minimum of -5.91 percent. The mandated adjustment is a significant reduction to all MA plans, whether or not a particular organization's providers code conservatively. Further, the across-the board adjustment to equalize MA and FFS coding does not reflect what the "right" level of coding is. Many MA plans may be coding more thoroughly and accurately than providers in traditional FFS, whose payment is tied to services and procedures rather than diagnoses.

- **Normalization Factor:** ACHP urges caution in assuming a new trend in the Part C HCC normalization factor because of the unexpectedly large 2016 normalization factor increase. We continue to believe the normalization factor will remain flat as it has been since 2011 or possibly decrease as large numbers of healthy baby boomers become eligible over the next several years. We question the reliability of the 2016 experience in the development of the normalization factor, especially in light of the long lag time for reporting FFS claims data. We do not think CMS should use the 2016 factor in its projection of the 2018 normalization factor until additional data is available. If 2016 is used at all, we recommend that a better approach would be to compute a 5-year average of actual FFS normalization factors, 2012-2016, as the basis for predicting the 2018 FFS normalization factor.

- **Use of the Encounter Data System as a Source for Risk Adjustment:** There continue to be significant problems with plans transmitting data and reconciling the data submitted to CMS. There also appear to be problems with CMS identifying the diagnoses submitted through EDS as those diagnoses associated with risk adjustment. In light of the problems developing complete and accurate risk scores from EDS, documented by GAO in its January, 2017 report, ACHP strongly recommends that CMS not use EDS data for risk adjustment in 2018.

- **Consolidation of Contracts**: While the issue is not addressed in this Notice and Call Letter, MedPAC has pointed out that when MA contracts are combined, the surviving contract determines the star rating of the new single contract, regardless of its enrollment size. Current rules for aggregating contracts into a single contract invite this gaming, which is particularly egregious when contracts are in distinct geographic areas and have different star ratings. ACHP supports MedPAC's proposal to maintain the star rating for each separate geographic area or market area and recommends that CMS make this change.

**Section-by-Section Comments**

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 27 states and the District of Columbia, providing both private and public coverage to nearly 19 million Americans, including 2.3 million Medicare beneficiaries. Six of the 14 5-star MA/PD plans are ACHP member plans, in addition to two 5-star, MA-only plans. Eighty-five percent of enrollment in 5-star plans is in plans offered by ACHP members.

Our specific comments are organized in the order that issues appear in the Advance Notice and Call Letter. We would be happy to answer any questions or provide assistance as you finalize guidance for the 2018 plan year.

## Attachment I. Preliminary Estimate of the National Per Capita Growth Percentage and National Medicare Fee-for-Service Growth Percentage for 2018

**Section A. MA Growth Percentage and Section B. FFS Growth Percentage** (p. 5)

**Develop USPCCs Using the Costs of FFS Beneficiaries Enrolled in Parts A and B:** ACHP recommends that the USPCCs that determine the MA growth percentage and the FFS growth percentage should use only the costs of the FFS beneficiaries enrolled in both Medicare Parts A and B. Please see our additional comments on this issue under Section B, Calculation of FFS Costs.

**Proposed Statement in Advance Notice Reflecting Full Phase-in of County Benchmarks:** ACHP encourages CMS to note in the Advance Notice that the MA growth rate is now used solely for the purposes of developing the benchmark cap. It is also helpful to indicate that MA and FFS growth rates should be very close to each other now that the county benchmarks are based solely on FFS costs.

## Attachment II. Changes in the Part C Payment Methodology for CY 2018

**Section A. MA Benchmark, Quality Bonus Payments and Rebates** (p. 9)

**Advance Notice Should Forecast the Impact of Rebasing:** ACHP recommends that CMS publish an estimate of the impact of rebasing in the annual Advance Notice, even if there are limitations to the estimate. OACT could release a file estimating the upcoming contract year's county benchmark (county FFS costs) using a 4-year average geographic adjuster with the last historical year dropped from the calculation, the same year that will be dropped when the Final Notice is released with final rates. The only data point missing from this calculation would be the latest year that is not yet available at the time of the Advance Notice release. All other data in this file will be updated when the final rates are released in the Final Notice, e.g., USPCCs and adjustments to update the FFS claims data to be more current. The estimate would help MA plans understand some of the impacts proposed in the Advance Notice on the AGA methodology. We assume that these calculations could be performed on the 4 years of historical county FFS claims data that are available at the time of the Advance Notice.

For example, an MA plan located in Miami-Dade county, a fully phased-in county, experienced a decrease of 7.2 percent in its 2017 county benchmark after the 2017 Advance Notice had announced a 2.9 percent *increase* in the national FFS costs per capita. Rebasing was the primary cause of this very large change. Upon further review, the FFS costs in the county's oldest historical year (2009) used to project the 2016 county FFS costs showed significantly higher FFS costs than occurred in more recent years. That year, 2009, is dropped from the 5 year average used in the 2017 county projection. The

result is a -7.6 percent change in the 2017 average geographic adjuster. This significant change is difficult to forecast but could be better anticipated if the proposed file is released at the time of the Advance Notice.

We understand that this proposed file of county rates will change in the Final Notice, and some county rates could change significantly when the most current historical year is added to the calculation at the time of the Final Notice. CMS will need to make clear that this file is a preliminary estimate of the impact of rebasing at the time of the Advance Notice. But we believe that the data would help plans better understand the likely impact of dropping the oldest historical year in the 5 year average geographic adjuster and, overall, help plans forecast the impact of rebasing at the time of the Advance Notice.

**Rebasing Frequency:** We suggest that CMS consider not rebasing every year. Stability and predictability of payment are important attributes of any payment system, and year-to-year changes of significant magnitude are disruptive in setting benefits and premiums. Stability is particularly important for integrated systems, such as many ACHP member health plans, given the capital invested in their owned medical centers and physician offices. After a year in which CMS does not rebase, OACT could use a 6-year (instead of a 5-year) average of the geographic adjusters to reduce the instability of the county benchmarks. Another approach would be to limit the rebasing change to no more than 2 percent in any given year.

**A.4. Qualifying County Bonus Payment (**p. 13**):**
CMS notes that one of the three criteria for a qualifying county bonus payment has been calculated incorrectly since its inception in 2012. In comparing county monthly FFS costs per capita to the national monthly FFS costs per capita, CMS mistakenly excluded Graduate Medical Education (GME) spending in county costs but included GME spending in the national FFS costs.

ACHP recommends the following county-to-national comparison be made so that it is clear that the two comparators are always on par with each other: The county FFS cost should be the CMS projection of 2018 county FFS costs, i.e., 100 percent of FFS costs. The national FFS cost per capita should be the summation/aggregation of all 2018 county FFS costs per capita.

Our proposal is a similar calculation to that which OACT uses to develop the Geographic Adjuster (GA) in the Average Geographic Adjuster (AGA) to project the county's FFS costs. For the GA calculation in each of the 5 historical years used to project the county FFS costs, the national FFS cost per capita amount in each of the 5 years is the summation of all the county FFS per capita costs. Using this same methodology for calculating the national per capita amount for the third qualifying county criterion would ensure that the national FFS costs would always include the same adjustments that are proposed to forecast the upcoming contract year's county FFS costs. For example, for 2018, OACT proposes that the county FFS claims be adjusted to account for the Medicare Shared Savings Program (MSSP) ACOs and Pioneer ACOs. By using the summation of all the county FFS costs as the national FFS cost comparator, this particular adjustment will clearly be included in the national comparator amount.

This change will be a significant reduction for counties no longer eligible for the qualifying bonus. ACHP proposes that CMS phase in this change over 2 years starting in 2019 and listing in the Final Notice the counties affected by the new methodology.

**A.6. Quality Incentive Payments/Cap on Benchmarks** (p. 14)**:**
ACHP urges CMS to finally correct the substantial losses to America's seniors from implementation of the benchmark cap that has reduced or eliminated quality incentive payments. CMS should use new authority granted in the President's executive order of January 20, 2017 to:

> "…waive, defer, grant exemptions from, or delay the implementation of **any provision or requirement** of the Act that would **impose a fiscal burden** on any State or a **cost**, fee, tax, **penalty**, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications." (emphasis added)

The benchmark cap clearly meets the test of this executive order as a fiscal burden, cost, or penalty imposed on Medicare Advantage enrollees and health plans. Further, there is bipartisan agreement that the unintended consequence of the benchmark cap provision has been to undermine value-based care and diminish benefits to seniors worth tens of millions of dollars. The executive order, in addition to discretionary language in the law, provides the opportunity to correct this inequity.

ACHP appreciates that CMS "shares the concerns stakeholders have raised about any rate-setting mechanism that diminishes incentives for MA plans to continuously improve the care provided to Medicare beneficiaries, and concur[s] that a primary goal of developing the star rating system for MA has been to encourage plans to continuously improve the quality of the care provided to their enrollees."

Despite that statement, in the 2018 Payment Notice CMS continues to interpret the law in a way that is contrary to Congressional intent, denying Medicare benefits to seniors who enrolled in high quality plans specifically so they could take advantage of enhanced benefits. CMS' decision has reduced or eliminated quality payments to plans in about half the nation's counties, affecting 2.5 million beneficiaries. In some areas, 4- and 5-star MA plans may receive the same payment as a 3-star plan, contrary to CMS' goal of paying for value. The benchmark cap interpretation has also limited the effects of CMS' initiative to account for the effects of high enrollment of dual eligibles on star ratings, as achieving a 4-star rating will do little if the plan with high numbers of dual eligibles is in a capped county.

This treatment of MA quality payments stands in stark contrast to other quality programs in Medicare. In other Medicare programs, if a provider meets the required metrics for a quality payment, he or she receives that payment irrespective of other payment or formula reductions.

Unfortunately, CMS has not used the discretionary authority it has exercised in so many other areas to correct this problem. We continue to believe that the statute allows the Secretary discretion to exclude the quality payments from the benchmark cap calculation. We have previously shared our legal analysis with CMS and would be glad to provide another copy.

CMS states that section §1853(n)(4) of the Social Security Act specifies that the quality bonus payment (QBP) must be included in the benchmark before the comparison is made to determine if the cap is required. However, the language in section 1853(n)(4) directs the Secretary to "take into account" the QBPs, which indicates that the Secretary should *consider* those payments but has the discretion to omit them from the cap calculation. This interpretation of the statute would be consistent with how the "taking into account" language is used elsewhere in section 1853 of the Act and in many other provisions of title VXIII of the Act.

The language used in §1853(n)(4) lacks the level of precision and detail that is used in §1853(n)(l), (2),

and (3). In those paragraphs, when Congress sought to establish rules for the calculation of the blended benchmark in terms that plainly limited the Secretary's discretion, Congress used *computational* language. For example, the specified amount is the product of county FFS costs and the "applicable percentage" that applies to all counties in a particular quartile determined under §1853(n)(2)(B). This specific direction is in stark contrast to the language in §1853(n)(4), which directs the Secretary, in determining a blended benchmark amount for an area and year, to ensure that the blended benchmark amount (which for years after 2012 is the specified amount) does not exceed the applicable amount that would otherwise have applied under section 1853(k) for the area and year, *but only after "taking into account" the quality payments* and, presumably, how to continue those payments authorized in the same Act. Had Congress intended for the cap to apply on a plan-specific basis and to be calculated in the manner of a mathematical formula, it could have written a more direct and computational provision.

The discretion allowed by the statute is further strengthened by the President's executive order. ACHP urges CMS to use these authorities to allow full payment of quality bonuses in 2018 to plans at 4 stars and above in all counties, as intended by Congress.

**Section B. Calculation of Fee for Service Cost** (p. 16)

**County Benchmarks Should Be Calculated Based on the Costs of the FFS Beneficiaries Enrolled in both Medicare Parts A and B:** ACHP recommends excluding the costs of the Part A-only FFS beneficiaries from the county benchmark calculation. This population's costs are likely to be very dissimilar from the FFS population enrolled in both Parts A and B because of the higher cost sharing the beneficiary faces if he/she uses health care services that are not covered by Medicare. If a county has a disproportionate share of these beneficiaries, the FFS costs of the county – and therefore the MA benchmarks – are likely to be underestimated compared to the costs of the MA population which receives both A and B benefits.

We believe that the county benchmarks should be based on a population with similar characteristics to that of the MA population. It is often the case that FFS costs and MA payment rates are compared to each other when there is policy discussion of whether MA plans are paid "fairly." The proposed change, which should be implemented without a requirement for budget neutrality, would make this comparison fairer and more equitable.

MedPAC notes that Part A-only enrollees currently represent 12 percent of the FFS beneficiaries and that this population is increasing. The share of FFS beneficiaries varies by county, especially in counties with large numbers of Federal retirees, and could have a large impact on a county's benchmark in some instances. In addition, as MA penetration continues to increase, FFS costs in those counties will be based upon a disproportionate share of Part A-only beneficiaries. As a result, without a correction, the county benchmark calculation will be less accurate in representing the overall FFS population.

ACHP recognizes there are several issues which CMS will have to consider. Among them are: whether to recalculate the geographic indices of the past five years based on the new methodology; whether or not to phase-in the change and, if so, over what time period; the effect on the benchmark quartile into which the county falls; and the effect on double bonus counties.

**Section G. MA Employer Group Waiver Plans** (p. 25)**:**
ACHP believes the methodology for transitioning to use of the individual bid to benchmark ratio as the basis for EGWP Part C base payments raises questions and needs further study. The current approach of separating bid to benchmark ratios by county quartile does not seem to show a significant difference in

the ratios in the second, third, and fourth quartiles – 92.2, 93.3, and 93.6 percent respectively. One would expect the bid to benchmark ratios to show a large difference between the lowest and highest county benchmarks, but that seems not to be the case. The methodology makes the calculation more complicated without adding much differentiation.

ACHP suggests that CMS consider breaking down the individual bid-to-benchmark ratio by a more local geographic area, e.g., Metropolitan Statistical Area, CMS Region or county, if possible. We believe there may be different market forces by geography that affect local plans' bid-to-benchmark ratios that are not reflected by national averages.

Given the need for further analysis and the significant impact of fully transitioning in 2018 to the individual bid to benchmark ratio, we recommend, at a minimum, an additional phase-in year at a 50/50 blend of the individual and EGWP bid to benchmark ratios.

ACHP supports CMS' proposal to continue to waive the requirement for MA EGWPs to allocate rebate dollars to any specific purpose for 2018.

**Section H. Medicare Advantage Coding Pattern Adjustment (**p. 28):
ACHP appreciates CMS' proposal to update the coding intensity adjustment by no more than the statutory minimum. However, we believe that the across-the-board adjustment unfairly penalizes MA plans that code conservatively. Further, the adjustment does not take into account what the "right" level of coding is. Many MA plans may be coding more thoroughly and accurately than providers in traditional FFS, whose payment is tied to services and procedures rather than diagnoses.

We note CMS' projection in the fact sheet issued on Feb. 9, 2017 that MA plans on average would realize a revenue gain of 2.5 percent from coding trends. CMS has not shared the data for this projection. After initial steps to improve the collection and reporting of diagnoses, including adoption of electronic medical records, and now that MA plans have years of coding experience, mature MA sponsors have reached a "steady state" of accurate reporting of diagnoses for risk adjustment. Given that, one would expect the coding patterns of MA plans and FFS Medicare to converge, primarily reflecting the illness burden of the population. In fact, we would expect downward pressures on future coding due to the growing enrollment of younger and healthier beneficiaries of the baby boom generation. Also, a number of risk adjustment studies suggest that enrollees who switch from FFS to MA tend to be healthier than their demographic cohort in FFS; that should drive coding down as well.

ACHP encourages CMS to share its data on coding trends and variations in those trends by geography, plan type, newer v. older MA plans, and other factors. CMS should provide data on coding trends over the past five years and the methodology used to forecast the 2018 trend. It is especially important for stakeholders to review this data because 2018 is the last year of congressionally mandated coding adjustments. Until data is available on coding pattern variations and there is an attempt to understand differences in coding between MA and FFS, ACHP believes there should be no extension of the coding adjustment beyond the 2018 plan year.

**Section I. Normalization Factor** (p. 29):
ACHP appreciates that CMS has shared the data and its proposal for calculating the 2018 normalization factor for the CMS-HCC model.

It is difficult to predict a change in trend when forecasting from historical data. In this case, the latest year's data point shows a large increase after many years of a flat trend. The question is whether this latest data point portends what is likely to occur in the future or is it simply an anomaly. We cannot

know the answer to that question now, so we hope that CMS will not project a trend based on a one-year increase.

In fact, we would expect a trend in the opposite direction. Given the influx of younger, healthier enrollees as baby boomers become eligible for Medicare, there should be downward pressure on the FFS normalization factor in the future.

We request that CMS describe how the data point of 1.022 was calculated for 2016, especially when the year has just ended. Given the lag in reporting complete and accurate FFS claims data, calculating risk scores for 2016 cannot be done until at least a few months after the calendar year. Because this data point may not be fully credible due to the data lag, we do not believe it should be used in any forecasts at this time.

In light of the difficulty of forecasting trends, if 2016 is used at all, we think that a better approach would be to compute a 5-year average of the historical normalization factors for the years 2012 to 2016. This approach would minimize the impact of what appears to be an outlier for 2016 and allow time for CMS to determine whether the 2016 factor is an anomaly or the beginning of a change in the trend. Our proposed methodology is the same type of calculation OACT uses to forecast county FFS costs, except with a longer lag in the FFS cost data (using 2011-2015 FFS cost data for the 2018 FFS cost projection). Using a 5-year average, the 2018 normalization factor estimate would be 1.003.

**Section K. Encounter Data as Diagnosis Source for 2018** (p. 35):
Given the continued problems of the Encounter Data System (EDS) reporting complete and accurate diagnosis data for the risk adjustment calculation, ACHP urges CMS to take a step back for 2018 and not use EDS as part of any blend in developing risk score. There are too many significant problems with EDS from both a health plan and CMS perspective, as documented in a recent GAO report, *Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments*.

From CMS' perspective, the GAO report found that CMS has not:

- developed requirements for data completeness and accuracy;
- performed statistical analyses to detect certain validity issues;
- reviewed medical records to verify diagnoses and services listed in encounter data; or
- reported what it had learned about data quality to MAOs.

From a health plan perspective, the GAO report found the following:

- errors in identifying diagnoses used for risk adjustment
- inclusion of encounter data elements considered irrelevant
- technical problems with encounter data submission
- inadequate CMS communication with individual MAOs

ACHP member plans continue to be unsure whether CMS is properly distinguishing diagnoses that are used for risk adjustment from those that are not used. Our members are not able to fully reconcile encounter data because they have not received all the necessary MAO-004 reports in a timely way. In addition, the EDS is not processing encounters according to current Medicare billing practices, with the result that health plans are not receiving credit for thousands of claims and, consequently, some diagnoses due to these discrepancies. As a result, some plans are seeing as much as a 2 percent reduction in risk adjusted payments compared to reporting under RAPS.

In performing risk assessment and risk adjustment using Hierarchical Condition Categories (HCCs), the diagnoses and demographics of an individual should determine that individual's risk score, no matter what is the data source of that risk score. A plan's prospective costs in the upcoming year are highly correlated to the plan's risk score. That is the purpose of risk adjustment: making payments to plans based on expected future costs for enrolling a certain population. If a data source that reports the demographics and diagnoses is, in fact, accurate, the plan's fully risk adjusted payment should be paid based on that information, no matter the source. Until RAPS and the EDS report diagnoses data in an equivalent way and CMS can show that the two data sources are equivalent, ACHP recommends that EDS not be used for risk adjustment, even as part of a blend for risk score determination.

If CMS continues to use EDS as part of a blended risk score, ACHP proposes the following adjustment: CMS should calculate what the industry risk score average is under 100 percent RAPS and 100 percent EDS, and then calculate the factor that adjusts the EDS risk score up to and equal to the RAPS score. CMS would then apply this factor to the EDS blended portion of each plan's risk score. As an example, if the industry average risk score under RAPS is 1.00, and the industry average risk score under EDS is 0.75, the factor applied to every plan's EDS risk score would be 1.33 (1.00/0.75) as part of the blend.

## Attachment III. Changes in the Payment Methodology for Medicare Part D for CY 2018

### Section A. Update of the RxHCC Model (p. 37)

ACHP supports updating the RxHCC model periodically to reflect the phased reduction of the coverage gap, particularly as plan liability for coverage of brand and specialty drugs increases.

ACHP encourages CMS to consider developing a hybrid prospective and concurrent risk adjustment model for the next recalibration. A hybrid model would take into account the many new, high cost drugs that are only taken for a short period of time until the patient is cured or the drug is no longer needed, e.g., drugs for Hepatitis C. For short-term (but expensive) drugs, if the diagnosis and costs are in the prior year, the higher costs may not be accurately accounted for in a prospective risk adjustment model.

## Attachment VI. CY2018 Draft Call Letter

### Section I. Parts C and D

### Adjusting Star Ratings for Audits and Enforcement Actions

ACHP supports CMS' decision to not reinstate the reduction in the overall and summary star ratings of contracts that are under sanction. While operational requirements should be part of the evaluation of contracts, we believe the star ratings primarily should reflect and maintain a focus on clinical care and member experience. We appreciate that CMS' decision on this issue reflects that perspective.

ACHP generally supports CMS' proposed revisions to the Beneficiary Access and Performance Problems (BAPP) measure. Specifically, we support changes to the data timeframe that allows for more recent data, and capping the deduction for civil monetary penalties (CMPs) at 40 points total instead of 40 points per CMP. However, we remain concerned that plans which are undergoing an audit will continue to be disproportionally disadvantaged on the measure because CMPs tend to be identified during an audit. Also, given the revisions, we believe it appropriate to use the BAPP measure as a display measure in 2018 and a star ratings measure in 2019.

We also appreciate that CMS is not moving forward with its proposal from the November Request for

Comments to change the weight of the BAPP measure to 3, and instead is maintaining a weight of 1.5 as an access/experience measure. We continue to believe this is a process measure. If CMS includes the measure in 2018 star ratings, we reiterate our recommendation that the revised measure should be assigned a weight of 1.

### *2018 CMS Display Measures*

#### Statin Therapy for Patients with Cardiovascular Disease (Part C) and Statin Use in Persons with Diabetes (SUPD) (Part D)

As CMS considers including these two statin measures in the 2019 star ratings, we encourage CMS to think about how the NCQA-developed cardiovascular disease measure and the PQA-developed SUPD measure might be better aligned. A major concern is that the PQA measure does not allow for the exclusion of statin-intolerant patients from the denominator, while the NCQA measure does permit the exclusion. Allowing for this exclusion is important to ensure that providers and plans have confidence in the reliability and accuracy of the measure.

We also recognize that a benefit of the PQA measure is its ability to be reported on a monthly basis via the patient safety dashboard, unlike the NCQA measure. In this respect, the NCQA measure has less transparency than the PQA-developed measure. We point out the relative strengths and weaknesses of both versions to demonstrate the need for CMS to work with measure developers to come to a consensus on the best way to gather and report data on statin therapy. Given the importance of appropriately accounting for statin-intolerant patients, we would recommend the use of NCQA-developed statin measures as the starting point for that discussion.

#### High Risk Medication (Part D)

ACHP supports the removal of the high risk medication measure from the 2018 star ratings and its transition to the display page. We encourage CMS to maintain the measure on the display page while changes are made to the measure specifications.

#### Providing More Detail on Display Page Measures

ACHP recommends that CMS provide more detail when publishing data on the display page measures. By providing plans with cut-point and national percentile data on these measures, CMS would allow plans to better gauge their performance relative to others, spurring quality improvement even before the measure appears in the star ratings.

### *Forecasting to 2019 and Beyond*

#### Telehealth and Remote Access Technologies

ACHP supports CMS' consideration of including telehealth and remote access technology encounters as eligible encounters in various Part C measures. However, we recommend CMS allow NCQA, the measure steward, time to evaluate the technical requirements of adding telehealth to HEDIS measure specifications before moving forward with including telehealth encounters in the display page.

As we have stated before, remote access technologies are a critical modality and complementary means of providing clinical services for many beneficiaries, especially those living in rural areas or with mobility issues. Given the benefits of telehealth to access and quality of care, we believe it is appropriate

to consider including telehealth encounters in certain Part C measures, in particular behavioral health, care coordination and transitions of care measures.

For example, we have previously made recommendations to NCQA to add telephone encounters by mental health providers to the criteria for HEDIS measures such as Follow-Up after Hospitalization for Mental Illness (FUH) and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). Though face-to-face delivery of care and services is often the preferred method, there is a growing body of evidence that indicates telephonic delivery may be equally effective. Telephonic contact would be helpful at increasing the success rate of that first contact as well as the likelihood of engaging members and preventing relapse or readmission. The efficacy of telephonic outreach associated with the medical home model in treatment of chronic medical illness may be an indicator of potential for similar success with mental health diagnoses.

Another example of an appropriate inclusion of telehealth encounters is in the Transitions of Care measure that CMS is considering for the display page in 2020, specifically the Patient Engagement After Inpatient Discharge indicator. For enrollees in rural areas who may face travel distance and transportation issues, telehealth encounters are an important tool to ensure continued patient engagement with a primary care provider after discharge.

As CMS continues to examine the possible inclusion of telehealth encounters in various Part C measures, we also recommend CMS address other issues related to encounter data and risk adjustment. Specifically, we ask that CMS provide additional guidance on whether telehealth encounters satisfy the "face-to-face" requirement for MA risk adjustment, and that CMS adjust the encounter data submission process (in particular the filtering logic) to allow for the inclusion of modifiers and/or place-of-service codes to denote telehealth encounters.

**Depression Screening and Follow-Up for Adolescents and Adults (Part C) and Alcohol Screening and Follow-Up (Part C)**

ACHP is concerned with the reliance on electronic clinical data systems in order for plans to report the depression screening and alcohol screening measures. For example, plans cannot include patients in the denominator for the depression screening measure unless they have direct access to those patients' electronic medical records (EMR) in order to get the PHQ-9 score. Plans have varying access to EMRs, and there are many with no access to EMRs. For these plans the measures would be completely unmeasurable. We urge CMS to address the significant challenge posed by the reliance on electronic data systems as it continues to consider these measures.

**Section II. Part C**

***Maximum Out-of-Pocket (MOOP) Limits***

CMS has noted that the number of MA plans with voluntary MOOPs has decreased significantly over the past several years. We believe the move to the mandatory MOOP can be attributed to the fact that, over time, CMS has reduced the difference in maximum cost sharing by service category between MAOs with the voluntary MOOP and mandatory MOOP. In addition, moving to a higher MOOP is a benefit change that affects only a small segment of the population.

ACHP recognizes that a lower voluntary MOOP benefit helps the frailest and highest cost members. We encourage CMS to continue to incentivize MA plans to offer the lower voluntary MOOP.

We recommend that CMS make some changes to the MOOP values that will strengthen the actuarial incentives for MAOs to offer the voluntary MOOP. First, CMS could change the maximum copays between the two MOOPs on those service categories that have higher utilization by Medicare beneficiaries, e.g., primary care physician, physician specialist, emergency care, and so on. At this time, these services have the same maximum copays under each MOOP. In considering which MOOP to offer as part of their overall benefit package, MA plans will take under consideration which MOOP offers service categories that will allow the plan to charge a higher copay that will result in a larger actuarial value of copayments (utilization multiplied by copays). A plan will be more likely to offer the Voluntary MOOP if the plan can charge a higher copay, for example, on primary care physician visits under the voluntary MOOP than under the mandatory MOOP because changing that copay results in a significant actuarial value. The more service categories that CMS differentiates between the MOOPs, especially for those services with higher Medicare utilization, the more likely an MA plan will choose to offer the voluntary MOOP.

Second, CMS could move to reduce the dollar difference between the MOOPs. It has been many years since either MOOP has changed from $3,400 or $6,700. Over time, we would encourage CMS to update the voluntary MOOP to a higher value while maintaining the mandatory MOOP at $6,700; an alternative is to update the mandatory MOOP at a lower trend. There are many alternatives for trending the voluntary MOOP. OACT uses the cost distribution of Medicare beneficiaries to currently set MOOP values. Because the MOOP limit has not changed for many years, this suggests that the cost distribution has not changed in many years. To better incentivize MA plans to choose the Voluntary MOOP, we suggest updating the limit by choosing among options such as: 1) USPCC increases; 2) actuarial value of Part A and B cost sharing; or 3) Medicare fee schedules. We would encourage CMS to trend the voluntary MOOP value by also rounding to the nearest $25 and rounding the mandatory MOOP by a smaller amount to ensure the differential between the MOOPs is reduced by a larger amount.

We believe that lessening the difference between the MOOPs, while increasing the copay maximum differentials on service categories that have higher Medicare utilization, will be a strong actuarial incentive for MA plans to move to the voluntary MOOP, a benefit that best serves the frail and high cost/high utilizing member.

## Additional Issues Not Included in Advance Notice and Call Letter

ACHP requests CMS consideration of the following two issues not included in the Advance Notice and Call Letter:

**Request for Additional Guidance on the Diabetes Prevention Program**

ACHP supports the Medicare Diabetes Prevention Program as a new and important covered benefit effective in 2018. However, before our members submit their MA bids in June, they will have to evaluate and enter into contracts with MDPP suppliers and finalize their benefit structures. This will require additional guidance from CMS and we urge you to provide that guidance as soon as possible.

One question that CMS should address is the “recognition status” of providers. The Centers for Disease Control has recognized the categories of pending and full recognition status. Most providers are now in pending status, according to CMS, and the process for achieving full status may take up to 3 years. For purposes of Medicare coverage, CMS has indicated that services may be provided by organizations with full or *preliminary* recognition status. Given the pending deadline for 2018 bids, we ask that CMS provide interim guidance on the determination of preliminary status and which providers qualify for contracting with MA organizations under the CDC pending recognition status.

CMS has also indicated that it is considering requirements for the virtual delivery of MDPP services. ACHP believes that providers should be able to deliver services through virtual technology as well as more traditional approaches. If a provider has either preliminary or full recognition status, it should be permitted to deliver services through the most effective and efficient means available, taking into account the needs of patients. ACHP recommends that CMS provide guidance allowing use of virtual modalities.

Given that the MDPP is new and will evolve and that these services must be incorporated in 2018 bids, we urge CMS to provide maximum flexibility to MA organizations on these and other questions related to administration of the MDPP benefit.

**Determination of Star Ratings of a Contract When Multiple Contracts of Distinct Geographic Areas Are Combined Into a Single Contract**

As MedPAC has pointed out, when contracts are combined under current rules, the surviving contract determines the star rating of the new single contract, regardless of its enrollment size. For example, if two contracts each with 3.5 stars and 100,000 members are consolidated into a surviving contract with 5 stars and only 10,000 members, the newly formed single contract will be designated as having a rating of 5 stars. This means all 210,000 members are now enrolled in 5 star plans for purposes of bidding, quality comparison, and quality bonus payments. The MA plans offered under these contracts can be in different and noncontiguous states.

The current rule for aggregating contracts into a single contract invites this gaming, which is particularly egregious when contracts are in distinct geographic areas and have different star ratings. We understand that CMS would like to reduce the number of contracts to reduce the administrative burden, but the star ratings of individual contracts before the aggregation should remain intact to eliminate artificial inflation of the ratings.

ACHP supports MedPAC's proposal to maintain the star rating for each separate geographic area or market area and we urge CMS to make this change. Bidding and rebate amounts would be based on the organization's star rating in the market area and not on the star rating of the single, surviving contract. Quality results and bonus payments would attach to an individual plan's enrollees in a specific market area, irrespective of the contract configuration.

Thank you for your consideration of ACHP's views. If there are questions or the need for additional information, please contact Howard Shapiro, ACHP Director of Public Policy, at hshapiro@achp.org.

Sincerely,

Ceci Connolly
President and CEO